U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation

Affordable Care Act (ACA) Funding Opportunity:

Accountable Health Communities (AHC)

Initial Announcement

Cooperative Agreement

Funding Opportunity Number: CMS-1P1-17-001

CFDA: 93.650

Date: January 5, 2016

Applicable Dates:

FOA Posting Date:	January 5, 2016
Letter of Intent to Apply Due Date:	February 8, 2016
Electronic Cooperative Agreement Application Due Date:	March 31, 2016 (1:00 p.m. Eastern Standard Time)
Anticipated Issuance of Notices of Award:	November 1, 2016
Anticipated Cooperative Agreement Period of Performance:	January 01, 2017 – December 31, 2021

Table of Contents

List of Figures

List of Tables

1. Executive Summary

The Accountable Health Communities model, as authorized under section 3021 of the Affordable Care Act (ACA), provides funding opportunities to community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations and for-profit and not-for-profit local and national entities for the purpose of testing whether systematically identifying the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries, and addressing their identified needs impacts those beneficiaries' total health care costs and their inpatient and outpatient utilization of health care services.

Item	Description
Funding Opportunity Title:	Accountable Health Communities
Announcement Type:	New
Funding Opportunity Number:	CMS-1P1-17-001
Catalog of Federal Domestic Assistance:	93.650
Letter of Intent to Apply Due Date:	February 8, 2016
Cooperative Agreement Application Due Date:	March 31, 2016 1:00 p.m. Eastern Standard Time
Anticipated Notice of Award:	November 1, 2016
Performance/Budget Period:	January 1, 2017 – December 31, 2021 - 5 years
Anticipated Total Available Funding:	Increase Awareness (Track 1): Up to $12 million, pending availability of funds Provide Assistance (Track 2): Up to $30.84 million, pending availability of funds Align Partners (Track 3): Up to $90.20 million, pending availability of funds

Item	Description
Estimated Number and Type of Awards:	Increase Awareness (Track 1): 12 Cooperative Agreements Provide Assistance (Track 2): 12 Cooperative Agreements Align Partners (Track 3): 20 Cooperative Agreements
Estimated Award Amount:	Increase Awareness (Track 1): Up to $1 million Provide Assistance (Track 2): Up to $2.57 million Align Partners (Track 3): Up to $4.51 million
Estimated Award Date:	November 1, 2016
Eligible Applicants:	Community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and non-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers.

2. Funding Opportunity Description

2.1 Purpose

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) will assess whether systematically identifying the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries, including those who are dually eligible, and addressing their identified needs, impacts those community-dwelling beneficiaries' total health care costs and their inpatient and outpatient health care utilization. The Accountable Health Communities (AHC) model addresses a gap in the current delivery system by funding interventions that connect community-dwelling beneficiaries with community services. The AHC model will test three community-focused interventions of varying intensity and their ability to impact total health care costs and inpatient and outpatient health care utilization. This model will engage community-dwelling Medicare and Medicaid beneficiaries of all ages (children and adults). CMS will award, through a competitive process, renewable one-year cooperative agreements to successful applicants (award recipients). Applicants may apply to participate in one or two tracks, but successful applicants will be selected to participate in a single track only. Each track will run for a five-year period. Parameters for each AHC model track are described in this Funding Opportunity Announcement (FOA).

2.2 Authority

Section 1115A of the Social Security Act (the Act), as added by section 3021 of the ACA, authorizes CMMI to test innovative payment and service delivery models to reduce Medicare, Medicaid, or CHIP expenditures, while preserving or enhancing the quality of all beneficiaries' care. The AHC is a payment and service delivery model under section 1115A that tests whether the systematic identification of health-related social needs in clinical settings, along with addressing those needs through referral to community resources and navigation services, impacts overall health care cost and inpatient and outpatient health care utilization.

2.3 Background

In January of 2015, Secretary Sylvia Burwell, of the Department of Health and Human Services (HHS), announced goals for Medicare to tie 30 percent of fee-for-service payments to quality or value through alternative payment models by the end of 2016 and 50 percent by the end of 2018. These goals are part of an overarching effort to transform the Medicare program, and to move the U.S. health system at large, toward paying for value and not volume. CMS is testing a broad portfolio of alternative payment models that includes accountable care organizations (ACOs), patient-centered medical homes, and bundled payments. CMS has also invested $960 million into two rounds of state innovation awards to catalyze payment reform. Additionally, numerous projects and programs across HHS have explored varying methods of improving the connections between clinical and community services. These alternative payment and service delivery models and programs align with HHS goals for delivery system reform and aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

CMS is currently engaged in a limited number of Medicare and Medicaid program efforts to develop screening and referral protocols that improve patient access to an array of community service providers available to address health-related social needs. In theory, ACOs and Medicare Advantage (MA) plans have some degree of flexibility to address and fund the improvement of Medicare beneficiaries' health-related social needs, though in practice such interventions have not been standardized and are subject to varying levels of investment. Medicaid has substantial experience with a wide range of benefits that were designed to achieve improved clinical care and care coordination, generally for special populations. Some of these payment and service delivery methods include community service referral and navigation. For example, the Home and Community-Based Services (HCBS) Waiver program has a long history of providing social services and supports to the most vulnerable Medicaid beneficiaries.

Although there is some evidence that existing programs may have improved connections between clinical and community services and begun to address health-related social needs, these programs vary widely in their screening strategies, enrollment criteria, availability, method of delivering services, and degree of integration between clinical and community services. In the absence of a robust evaluation of critical program components, there is insufficient direct evidence of impact or value, and it remains unclear which strategies are most effective in addressing social needs to improve health and reduce health care costs.

Strategic collaboration between programs that pursue similar goals or serve similar populations may foster synergies in implementation and prevent duplicative program costs. The AHC model builds on the lessons learned from these and other efforts by encouraging the leveraging of

existing community service programs, using a robust evaluation approach, and testing promising interventions and a pricing strategy around these interventions. The AHC model will leverage opportunities created by existing programs and benefit from mutually strengthened service delivery resulting in greater impact, while not duplicating existing federal spending on similar services. The model will include an approach that touches all community-dwelling Medicare and Medicaid beneficiaries. The underlying concept of this population-based model test is that identifying and addressing health-related social needs has the potential to improve health care outcomes and reduce total cost of care.

The Accountable Health Communities (AHC) model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. This model includes the following elements: (1) screening of community-dwelling beneficiaries to identify certain unmet health-related social needs; (2) referral of community-dwelling beneficiaries to increase awareness of community services; (3) provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services; and (4) encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries. The expectation is that these efforts will lead to a reduction in health care utilization and costs.

2.3.1 Model Overview

Many of the largest drivers of health care costs fall outside the clinical care environment: only 20 percent of the modifiable variation in health outcomes is due to clinical care, whereas 40 percent is due to social and economic determinants, 30 percent to health behaviors, and 10 percent to the physical environment.[1] Some 500,000 hospitalizations could be averted annually if the rate of preventable hospitalizations were the same for residents of low-income neighborhoods as for those of high-income neighborhoods,[2] and unmet health-related social needs may play a significant role in that disparity.[3] With Medicaid investing over $69 billion in home and community based services (HCBS) alone and countless supports and services available through other service delivery systems, the coordination of non-medical drivers has significant implications for health care utilization.[4] Research suggests that community services that address these health-related social needs have the potential to reduce health care utilization and costs.[5]

Health-related social needs, such as food insecurity,[6] inadequate or unstable housing,[7,8,9] and interpersonal violence,[10] increase the risk of developing chronic conditions and reduce individuals' ability to manage these conditions.[11] They are also associated with increased emergency department (ED) visits and inpatient hospital admissions.[12,13,14,15] Historically, patients' health-related social needs have not been addressed in traditional health care delivery systems. Many health systems lack the infrastructure and incentives to develop systematic screening and referral protocols or build relationships with existing community service providers. The Accountable Health Communities (AHC) model seeks to bridge the divide between the clinical health care delivery system and community service providers to address these health-related social needs.

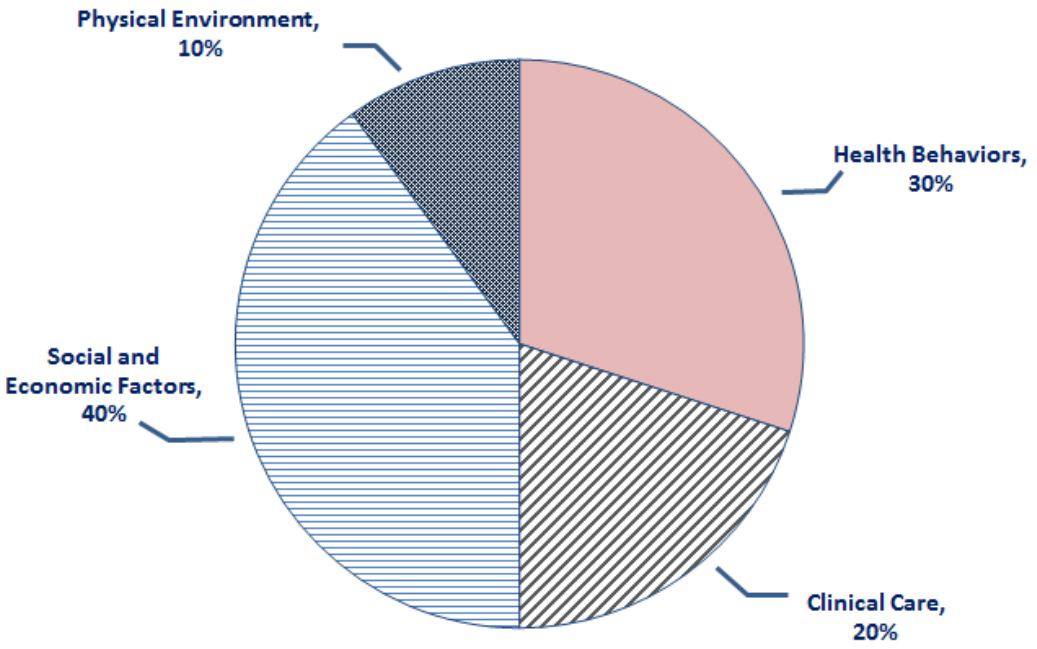

Figure 1. Modifiable Factors That Influence Health

The AHC model will test whether systematically identifying and addressing the health-related social needs of community-dwelling beneficiaries, including those who are dually eligible, (regardless of age, functional status, or cultural or linguistic background) impacts total health care costs and inpatient and outpatient health care utilization. Specifically, the AHC model will implement three interventions of varying intensity that link community-dwelling beneficiaries who have unmet health-related social needs to appropriate community services. The model design was informed by an assessment of current CMS models and programs, including ACOs, Medicaid Managed Care, Medicaid health homes, and HCBS programs. Additionally it was informed by a growing evidence base of promising service delivery models that integrate community services into the clinical setting. Evidence supporting the AHC model falls into two categories: (1) evaluations of the health effects of community services that address specific health-related social needs (e.g., housing problems, food insecurity); and (2) evaluations of approaches to link patients with community services.

Figure 2 summarizes the three intervention tracks utilized in the AHC model (each referred to as a "track") to better link community-dwelling beneficiaries with community services.

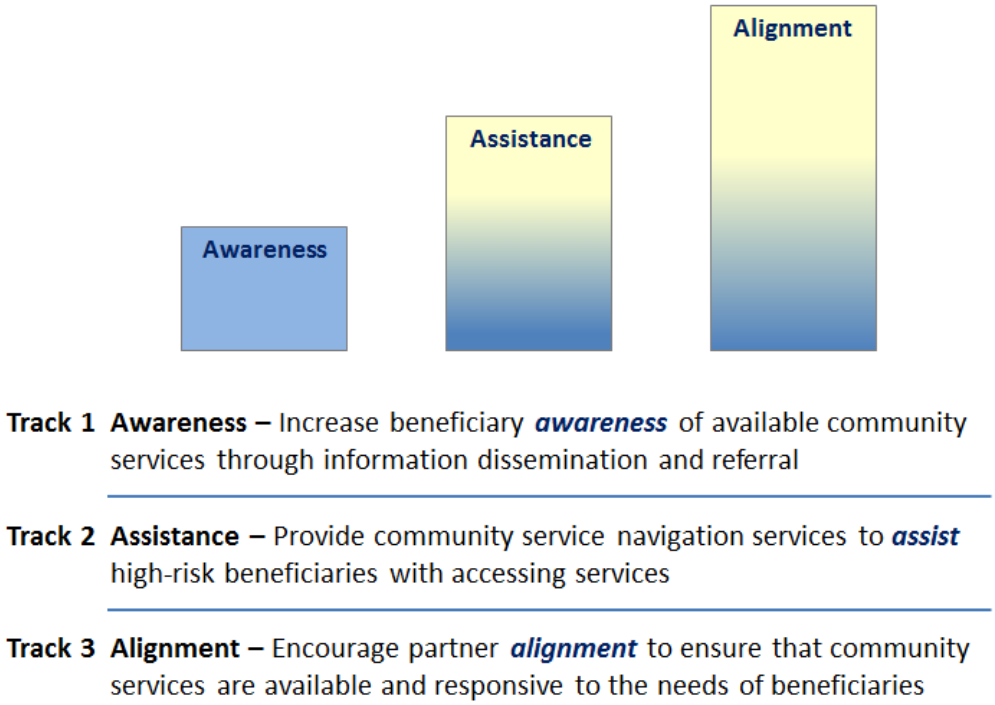

Figure 2. Summary of the Three AHC Intervention Tracks

Each of these tracks requires the award recipient to serve as a hub responsible for coordinating efforts to: (1) identify and partner with clinical delivery sites (CDS) (e.g., clinics, hospitals); (2) conduct systematic health-related social needs screenings and make referrals; (3) coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs and who are randomized to the intervention group to community service providers that might be able to address those needs; and (4) [Track 3 only] align model partners to optimize community capacity to address health-related social needs.

This funding announcement permits CMS to award up to 44 cooperative agreements to award recipients. Awards will range between $1 million and $4.51 million per award recipient, totaling approximately $122 million over a five-year period.

CMS funds for this model cannot pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation) received by community-dwelling beneficiaries as a result of their participation in any of the three intervention tracks. Award recipients, however, must use their award monies to fund interventions intended to connect community-dwelling beneficiaries with those offering such community services.

CMS will select award recipients using the following criteria:

- Can the applicant meet the intervention delivery requirements for the track to which it is applying;
- Can the applicant demonstrate that it has received, or has the means and wherewithal to receive, the commitment, collaboration and engagement of clinical delivery sites and other community stakeholders needed to implement the track for which it is applying; and

- Can the applicant demonstrate that it can provide to CMS and its contractors all required data necessary to evaluate the track to which the applicant is applying.

Table 1 summarizes the key aspects of each track's intervention.

Table 1. Summary of Key Intervention Elements by Track

Intervention Element	Track 1: Increase Awareness	Track 2: Provide Assistance	Track 3: Align Partners
Target Population	Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social need	Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social need	Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social need
Short Description	Referral only	Community service navigation	Community service navigation and partner alignment
Question Being Tested	Will increasing community-dwelling beneficiaries' **awareness** of available community services through information dissemination and referral impact total health care costs and inpatient and outpatient health care utilization?	Will providing community service navigation to **assist** high-risk community-dwelling beneficiaries with accessing community services in order to address certain identified health-related social needs impact their total health care costs and inpatient and outpatient health care utilization?	Will a combination of community service navigation (at the individual community-dwelling beneficiary level) and partner **alignment** at the community level impact total health care costs and inpatient and outpatient health care utilization?

Intervention Element	Track 1: Increase Awareness	Track 2: Provide Assistance	Track 3: Align Partners
Intervention	**Inventory** of local community services responsive to community needs assessment **Universal screening of all community-dwelling beneficiaries** who seek care from participating clinical delivery sites **Referral** to community services of community-dwelling beneficiaries with certain identified unmet health-related needs in intervention group, with community-dwelling beneficiaries responsible for completing referrals	**Inventory** of local community services responsive to community needs assessment **Universal screening of all community-dwelling beneficiaries** who seek care from participating clinical delivery sites **Referral** to community services *and* intensive **community service navigation** (in-depth assessment, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk community-dwelling beneficiaries with certain identified unmet health-related needs in the intervention group	**Inventory** of local community services responsive to community needs assessment **Universal screening of all community-dwelling beneficiaries** who seek care from participating clinical delivery sites **Referral** to community services *and* intensive **community service navigation** (in-depth personal interview, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk community-dwelling beneficiaries with certain identified unmet health-related needs in the intervention group **Continuous quality improvement** approach, including an advisory board that ensures community services are available to address health-related social needs, and data sharing to inform a **gap analysis** and quality improvement plan

Intervention Element	Track 1: Increase Awareness	Track 2: Provide Assistance	Track 3: Align Partners
Funding Categories	Funds are available for: start-up costs, screening and referral, and program administration.	Funds are available for: start-up costs, screening and referral, navigation services and program administration.	Funds are available for: start-up costs, screening and referral, navigation services, quality improvement activities and program administration.
Evaluation	Randomization	Randomization	Two matched comparison groups
Number of Award Recipients	12	12	20
Funds per Award Recipient	$1 million	$2.57 million	$4.51 million

2.3.2 Model Goals

The AHC model will fund award recipients to implement the track for which they are selected. Depending on the track, award recipients will be expected to achieve some or all of the following AHC programmatic goals:

- Increase community-dwelling beneficiaries' awareness of community resources that might be available to address their unmet health-related social needs;
- Increase the connection of high-risk community-dwelling beneficiaries with certain unmet health-related social needs to community resources through navigation services;
- Optimize community capacity to address health-related social needs through quality improvement, data-driven decision making, and coordination and alignment of community-based resources; and
- Reduce inpatient and outpatient health care utilization and the total costs of health care by addressing unmet health-related social needs through referral and connection to community services.

2.3.3 Key Definitions

Community-Dwelling Beneficiary. For the purposes of the AHC model, a community-dwelling beneficiary is a Medicare and/or Medicaid beneficiary, regardless of age, functional status, and cultural or linguistic diversity, who is not residing in a correctional facility or long-term care institution (e.g., nursing facility), who seeks health care at a participating clinical delivery site and who lives within the geographic target area specified by the applicant. This definition includes children and adults covered under Medicaid through presumptive eligibility, and all community-dwelling beneficiaries that are dually eligible.

1. **High-risk Community-Dwelling Beneficiary.** For the purposes of the AHC model, a high-risk community-dwelling beneficiary is a community-dwelling beneficiary with a health-related social need who self-reports 2 or more ED visits in the 12-month period prior to seeking care at the clinical delivery site where the community-dwelling beneficiary is offered screening.
2. **Low-risk Community-Dwelling Beneficiary.** For the purposes of the AHC model, a low-risk community-dwelling beneficiary is a community-dwelling beneficiary with a health-related social need who self-reports 1 or zero ED visits in the 12-month period prior to seeking clinical care at the clinical delivery site where the community-dwelling beneficiary is offered screening.

Community Services. For the purposes of the AHC model, community services are a range of public health and social service supports that aim to address health-related social needs and include many home and community-based services (HCBS). Examples include but are not limited to: a permanent supportive housing or other homeless assistance program administered by a local housing agency under a Continuum of Care;[16] a legal services program that assists low-income persons with employment, housing and financial issues; a cross-disability peer group that addresses issues that affect men and women living with disabilities; a hospital-based violence intervention program; programs offering transportation vouchers provided by a community service provider, described in the Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Community Service Providers.

Community Service Providers. For the purposes of the AHC model, community service providers increase access to: employment, education, or other essential health-related social needs; services to help community-dwelling beneficiaries apply for benefits such as energy assistance, or nutrition assistance; environmental modifications offered through local agencies and volunteer organizations; home-delivered meals offered through the Area Agency on Aging (AAA); a peer-based group to support recovery from substance use disorders; and family caregiver supports such as respite care. Many of these services are delivered by entities that are not typically considered to be health care organizations.

Health-Related Social Need. For the purposes of the AHC model, the term health-related social need refers to one or more community-dwelling beneficiary needs that can be linked to health care but may not be furnished along with clinical care. The *core health-related social needs* in the AHC model are defined as follows: housing instability and quality (e.g., homelessness, poor housing quality, inability to pay mortgage/rent); food insecurity; utility needs (e.g., difficulty paying utility bills); interpersonal violence (e.g., intimate partner violence, elder abuse, child maltreatment); and transportation needs beyond medical transportation.

The *supplemental health-related social needs* in the AHC model can include but are not limited to: family and social supports (e.g., prenatal support services, child care, social isolation, respite services, caregiver support); education (e.g., English as a Second Language (ESL), General Educational Development (GED), or other education programs impacting social determinants of health); employment and income; and health behaviors (e.g., tobacco use, alcohol and substance use, or physical activity).

All award recipients will offer a CMS-approved health-related social needs screening, for the core health-related social needs, to all community-dwelling beneficiaries who seek health care at a participating clinical delivery site. Award recipients may also screen for supplemental health-

related social needs using questions provided by CMS. Decisions to screen for supplemental health-related social needs should be based on community needs assessment findings in the communities being served by the intervention. If supplemental health-related social needs are screened for, then the community must have one or more existing community service providers to address those needs.

Usual Care. For the purposes of the AHC model, the term *usual care* describes the clinical care received by community-dwelling beneficiaries for the prevention or treatment of disease or injury. *Usual care* means clinical care that would be provided to the community-dwelling beneficiary whether or not the community-dwelling beneficiary is eligible for and receives an intervention under the model, and includes care that would otherwise be covered under Medicare and/or Medicaid. For purposes of the model, usual care also includes all federal and state reporting requirements (e.g., mandatory reporting of child abuse and neglect), recommended screenings (e.g., screening for intimate partner violence as part of the Women's Preventive Services Guidelines), and institutional and individual practice protocols (e.g., hospital guidelines and procedures).

Vulnerable Populations. For the purposes of the AHC model, vulnerable populations include community-dwelling beneficiaries who have suffered from health or health care disparities as defined by: race or ethnicity, religion, socioeconomic status, gender, age, mental health, disability status, sexual orientation, gender identity, and/or geographic location.

2.4 Program Requirements

This funding announcement offers three interventions of varying intensity (each referred to as a "track") to better link community-dwelling beneficiaries to community services: (1) Track 1 – Awareness, (2) Track 2 – Assistance, and (3) Track 3 – Alignment. Applicants may apply to up to two tracks (i.e., Tracks 1 and 2, Tracks 2 and 3, or Tracks 1 and 3). Although tracks share common design elements, each track's intervention pathway and underlying hypothesis is unique. Award recipients will be selected to participate in a single track for up to a five-year period of performance. The period of performance consists of five 1-year budget periods renewable based on satisfactory progress and the availability of funds. Switching between tracks during the period of performance will not be permitted.

The AHC model will test and evaluate three interventions of varying intensity to link community-dwelling beneficiaries with certain unmet health-related social needs with entities that might be able to address those needs. This model builds upon the promising practices identified in other CMS and HHS programs and initiatives. In all three tracks, award recipients will function as hubs that develop and maintain relationships with both clinical delivery sites, described in the Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection Clinical Delivery Sites, and community service providers, described in the Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Community Service Providers.

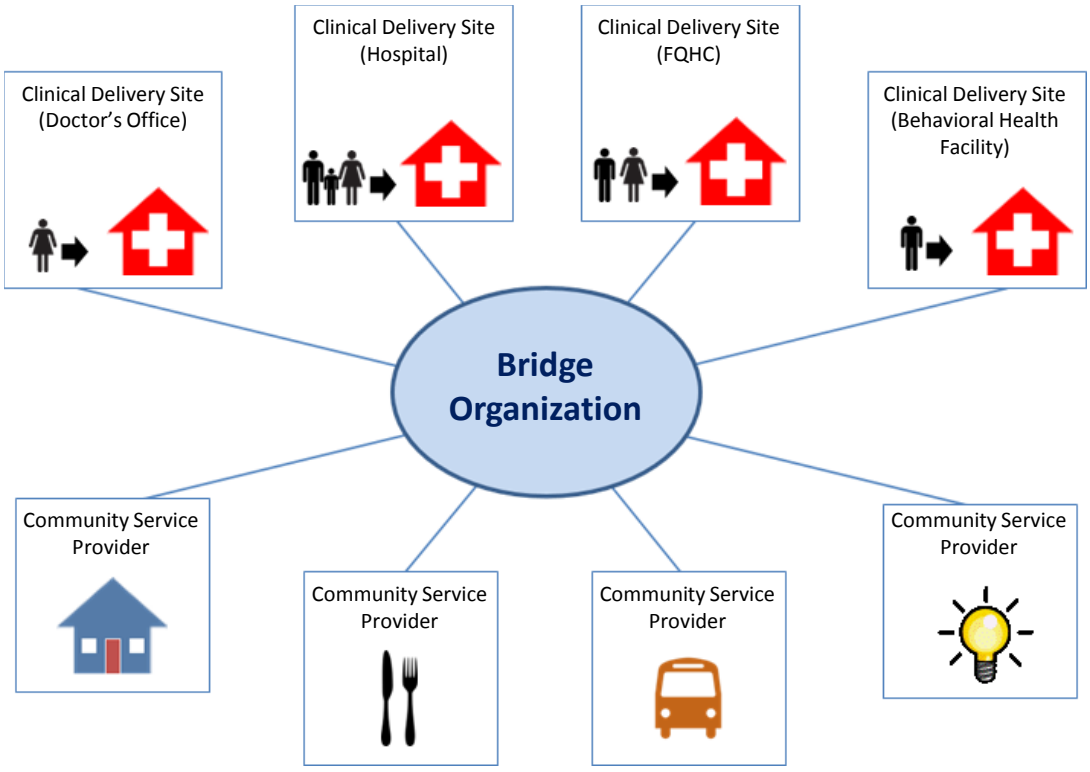

Figure 3. AHC Model Structure[17]

2.4.1 Model Test Proposal Requirements – All Tracks

Applicants

Applicants may consist of either a consortium, composed of collaborators led by a bridge organization, or a bridge organization that intends to form a consortium if awarded a cooperative agreement. Either way, such consortium must ultimately include at a minimum a bridge organization and a state Medicaid agency, and may also include any other participants in the model. State Medicaid agencies cannot serve as the bridge organization. In all cases, the bridge organization must serve as the lead award recipient.

The application must clearly identify whether it is being submitted by a consortium, composed of collaborators led by a bridge organization, or a bridge organization that intends to form a consortium if awarded a cooperative agreement. To that end, the application must contain a list of all consortium participants or potential consortium participants (including contracts, memoranda of understanding (MOUs), or other agreements equivalent to MOUs (MOU equivalents), along with a description of how the consortium will be structured (for example, through sub-grants or contracts). Listed below are required responsibilities of the bridge organization and state Medicaid agency.

No Waivers

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). The Secretary is not issuing any waivers

of the fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act or of any other Medicare or Medicaid laws. The award recipient, sub-award recipients, and all other relevant individuals or entities must comply with all applicable laws and regulations.

Additionally, CMS provides no opinion on the legality of any contractual or financial arrangement that the award recipients, sub-award recipients, clinicians, affiliated entities or any other relevant individuals or entities may propose, implement, or document. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules or regulations, and will not preclude CMS, HHS or its Office of Inspector General, a law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules and regulations.

Bridge Organizations

Bridge organizations, in the AHC model, may be community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, or for-profit or non-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers. The bridge organization will be responsible for the following in all tracks:

- **Clinical Delivery Sites.** The bridge organization must make arrangements with clinical delivery sites that provide clinical health care to provide the required AHC intervention services to community-dwelling beneficiaries (see Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Clinical Delivery Sites) in a manner that meets the track specific requirements and milestones (see Sections 2.4.1.2 Track 1- Awareness Intervention Proposal Requirements, 2.4.1.3 Track 2 – Assistance Intervention Proposal Requirements, and 2.4.1.4 Track 3 - Alignment Intervention Proposal Requirements, Subsections on Milestones). Bridge organizations may offer these screenings directly, through administrative or clinical staff under an agreement with the clinical delivery site or through arrangements with a third party. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Clinical Delivery Sites for details.
- **Screening Tool.** The bridge organization must use a standardized screening tool for health-related social needs populated with questions developed by CMS. The screening tool will contain initial threshold questions to determine eligibility for the full screening, screen for core health-related social needs that CMS has defined for the purpose of this model, and may also screen for supplemental health-related social needs supported by the results of a community needs assessment and for which CMS has developed appropriate screening questions. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Screening Tool for details.
- **Community Resource Inventory.** The bridge organization must develop and maintain a comprehensive database, updated at least every six months, that contains information on community service providers that may be able to address the health-related social needs that are screened for in the screening tool See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Community Resource Inventory for details).
- **Operating Procedures.** The bridge organization must develop and submit standard operating procedures (SOPs) to CMS, no later than 90 days prior to the end of the start-up period that applies to the track (Track 1 – Awareness three months; Track 2 –

Assistance six months; and Track 3 – Alignment nine months). CMS will provide feedback within 30 days of receipt. All SOPs must be finalized and approved by CMS before an award recipient can begin to deliver intervention services. CMS may request modification to SOPs to facilitate the linkage of program operations with CMS contractor functions (see Section 2.5 Technical Assistance and Information for Potential Applicants). SOPs must detail processes for implementing the intervention. This includes but is not limited to policies and procedures related to screening, data exchange, randomization, intervention fidelity (ensuring that the intervention is delivered as designed), avoiding duplication of existing services, and data reporting procedures. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Screening Tool and Community Resource Inventory for details.

- **Data Sharing.** The bridge organization must submit as part of the application a plan that describes how it will collect and share, or otherwise explain how it will ensure that its consortium members collect and share, with CMS any identifiable beneficiary-level data for purposes of model monitoring and evaluation. This includes data on who was screened, who accepted the intervention, what the results of the implemented intervention were, and information on both the availability and utilization of community services. Bridge organizations will be required to report, or ensure their consortium members' reporting of, such data to CMS and/or one or more CMS contractors as may be required for monitoring and evaluation purposes, and bridge organizations will be expected to facilitate data sharing in accordance with applicable laws among its consortium members. As the data required to be shared with CMS and its contractors includes beneficiary identifiers, bridge organizations should also describe how it intends to share such identifiable data in a secure manner. See Section 5.2 Application Structure and Content, Subsection on Data Sharing for details.
- **Assessment of Program Duplication.** The bridge organization must submit, as part of the application, a plan that addresses how it will ensure that CMS funding for this model does not duplicate services already made available through other programs. See Appendix 7: Assessment of Program Duplication for details.
- **Financial Integrity.** The bridge organization must certify in the application that it has financial and accounting systems that are fully auditable and able to document all AHC-related savings, revenues, and expenditures.
- **Community Engagement.** The bridge organization must demonstrate in the application that it already has, or has the capacity to develop, active relationships with community service providers.

Other Model Participants

State Medicaid Agency

Applicants will only be considered if their application includes certain written assurance(s) from the state Medicaid agency that would be expected to pay for Medicaid-covered services furnished to its community-dwelling Medicaid beneficiaries at the applicant's participating clinical delivery site. Where such participating clinical delivery sites would be expected to furnish Medicaid-covered services to community-dwelling Medicaid beneficiaries from more than one state, the applicant is expected to secure, at a minimum, assurances from such agencies

as may be needed to ensure participation by those State Medicaid agencies that collectively pay for the majority of such services furnished at such sites. All such assurances must document the agency's willingness to participate in the applicant's implementation of this model, and acknowledge that, as a model participant, it will be subject to 42 CFR §403.1110 (providing for model participants' production of such data to CMS or its contractors, including protected health information (PHI), as may be required to monitor and assess the model).

The state Medicaid agency must at a minimum, confirm its willingness to perform the following:

- Report or facilitate the reporting of Medicaid claims data to CMS and its contractors for purposes of model monitoring and evaluation;
- Champion appropriate data sharing across clinical delivery sites and community service providers consistent with federal, state and local law;
- Ensure alignment with existing Medicaid policy, and, as appropriate, waivers and State Plan Amendments to achieve scalability and sustainability if the model is successful;
- Provide a point of contact for data collection and reporting (The point of contact will be expected to communicate with CMS, CMS' monitoring and assessment contractors, the bridge organization, and the advisory board (for Track 3 – Alignment communities));
- Perform an annual review to ensure that CMS funding under the AHC model is not used to duplicate any service that a community-dwelling Medicaid beneficiary would otherwise be eligible to receive under a program administered by that state Medicaid agency; and
- Participate in the advisory board in the Track 3 – Alignment intervention.

Additional details on requirements for contracts, MOUs or MOU equivalents between the bridge organization and state Medicaid agencies can be found in the Section 5.2 Application Structure, Subsection on Contract, MOU or MOU Equivalent from State Medicaid Agency (see Section 2.4.5 Model Test Proposal Requirements).

CMS anticipates needing timely access to clinical data in order to monitor and assess this model. Applicants for all tracks therefore must have, or have plans to establish, relationships with clinical delivery sites and community service providers under which they agree to participate in the AHC model, and, in accordance with 42 CFR §403.1110, provide such data as is needed for such monitoring and assessment.

Clinical Delivery Sites

Applicants must include contracts, MOUs or MOU equivalents with clinical delivery sites in their application for participating hospitals, primary care provider or practice, and provider of behavioral health services. Applicants are required to establish agreements with clinical delivery sites serving community-dwelling beneficiaries, and are encouraged to include sites that can extend the reach of the intervention to vulnerable populations who have suffered health and/or health care disparities. Applicants must ensure that their consortium, through their participating clinical delivery sites, will be able to present opportunities to screen at least 75,000 community-dwelling beneficiaries per year. Track 3 – Alignment applicants must also be capable of reaching 51 percent of community-dwelling beneficiaries in the geographic target area.

Bridge organizations must establish relationships with at least one of each of the following types of clinical delivery sites (a single entity may fulfill more than one of these roles):

- *Hospital*. At minimum, the bridge organization must arrange to offer screening for health-related social needs to all community-dwelling beneficiaries who seek care from a hospital's Emergency Department, Labor and Delivery unit, and inpatient psychiatric unit (if applicable), and, when appropriate, provide the intervention specified in the Award. The bridge organization may also choose to offer screening in additional units of the hospital.
- *Primary care provider or practice.* The bridge organization must make arrangements to offer screening for health-related social needs to all community-dwelling beneficiaries who seek care from a primary care practitioner or provider, which may include a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), an individual practitioner, or a primary care practice. When appropriate, the arrangement must also include the provision of the intervention specified in the Award.
- *Provider of behavioral health services*. The bridge organization must make arrangements to offer screening for health-related social needs to all community-dwelling beneficiaries who seek care from a practitioner or provider of behavioral health services and, when appropriate, provide the intervention specified in the Award.

Additional details on requirements for the contracts, MOUs or MOU equivalents between the bridge organization and clinical delivery sites can be found in Section 5.2 Application Structure, Subsection on Contracts, MOUs or MOU Equivalents from Clinical Delivery Sites.

Community Service Providers

For the purposes of the AHC model, a community service provider is defined as any independent, for-profit, non-profit, state, territorial, or local agency capable of addressing core or supplemental health-related social needs identified through the screening tool (see Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Screening Tool for details). Bridge organizations in all three tracks must have or have the capacity to establish relationships with community service providers as they plan, implement, and monitor the interventions. In the Track 1 – Awareness and Track 2 – Assistance interventions, community service providers receive referrals. In the Track 3 – Alignment intervention, community service providers both receive the referrals and actively participate in service alignment.

Applications must include descriptions of the bridge organization's:

- Engagement strategy for community service providers;
- Plan for ensuring that all community-dwelling beneficiaries in the intervention group who receive an intervention are being referred to appropriate community service providers; and
- List of local coalitions or organizations focused on community capacity building around health-related social needs.

Additional details on requirements for the contracts, MOUs or MOU equivalents between the bridge organization and community service providers can be found in Section 5.2 Application

Structure, Subsection on Contracts, MOUs or MOU equivalents from Community Service Providers.

Geographic Target Area and Percent Capture of Community-Dwelling Beneficiaries

Applicants for all tracks must clearly describe in their applications the geographic target area in which a community-dwelling beneficiary must live in order to receive an AHC intervention (see definition of community-dwelling beneficiary). Descriptions could include zip codes, cities/counties, or any other unit that will make clear the specific boundaries of the geographic target area. Applicants proposing to deliver the AHC intervention to rural populations must address strategies for intervention fidelity (ensuring that the intervention is delivered as designed) in these communities, if awarded a cooperative agreement.

For an area to qualify as a geographic target area for Track 3 – Alignment, participating clinical delivery sites (or those that the applicant anticipates will participate) must have collectively provided health care services to at least 51 percent of the total population of community-dwelling beneficiaries who live in the geographic target area in the 12-month period prior to the date the application is submitted (or be able to adequately document that they will be able to screen this population during the performance period).

Applicants for all tracks must also clearly describe in their applications: the health-related social needs of the proposed geographic target area; how the health-related social needs were identified; and the applicant's logic for addressing the identified health-related social needs through the selected AHC intervention. The applicant must also describe the availability and capacity of community resources to address health-related social needs and the geographic reach of community service providers that may receive referrals under an AHC intervention. If the applicant intends to screen for supplemental health-related social needs, then the applicant should describe the need and ability to address these supplemental health-related social needs.

CMS will consider the geographic diversity of all applications when making cooperative agreement award selections. No more than one cooperative agreement will be awarded within a single geographic target area, if two or more applications identify the same or overlapping areas.

Screening Tool and Community Resource Inventory

Each bridge organization must use a screening tool, standardized across all participating clinical delivery sites to: determine community-dwelling beneficiaries' AHC intervention eligibility, identify health-related social needs, and maintain a community resource inventory of community service providers that may be able to address those health-related social needs. Such screening must, as a threshold matter, be able identify who is or is not a Medicare and/or Medicaid beneficiary and where that beneficiary resides.

Selection of Screening Domains

The screening tool must screen for core health-related social needs using questions provided by CMS, and may also screen for supplemental health-related social needs supported by the results of a community needs assessment and for which CMS has developed appropriate screening questions. See Appendix 5: Domains of Health-Related Social Needs for details.

Bridge organizations will be required to screen for all core health-related social needs for the entire duration of the performance period. Screening for supplemental health-related social needs

may be added or removed during the performance period, contingent upon approval by CMS. CMS encourages applicants and award recipients to review available community needs assessments to identify supplemental health-related social needs for which beneficiaries can be screened. Each supplemental health-related social need must be:

(1) Identified through a needs assessment that includes the geographic target area where community-dwelling beneficiaries that the bridge organization expects to participate in the model reside. Examples of a needs assessment that could be used include a hospital's community health needs assessment, a local health department's community health assessment, a State Mental Health Plan, a State Unit on Aging Plan, and a gap analysis;

(2) Included on the list of supplemental health-related social needs domains for which CMS has developed questions; and

(3) Able to be addressed by one or more existing community service providers.

Screening Tool

While CMS highly encourages the use of electronic methods to administer the screening tool, bridge organizations may choose any appropriate method to administer the screening tool (e.g., on paper, electronically, or by trained staff, such as a counselor, community health worker, or other designated professional). The tool must be made available to all community-dwelling beneficiaries regardless of language, literacy level or disability status (e.g., culturally and linguistically appropriate). Bridge organizations must pilot the screening tool during the start-up period.

Risk Stratification and Randomization

CMS will maintain a data collection system for programmatic data related to AHC intervention service delivery. This data collection system will be accessible to the bridge organization and clinical delivery sites, as appropriate. All community-dwelling beneficiaries participating in the AHC model will be assigned to the low-risk, intervention (i.e., high-risk in Track 2 and Track 3), control or not enrolled group (i.e., group assignment) based on responses to an initial health-related social needs screening and the intervention track evaluation design. The group assignment will be produced upon entry of health-related social need screening data along with individually-identifying information (e.g., Medicare or Medicaid identification number) into the data collection system. On subsequent visits (for the purpose of clinical care) to any participating clinical delivery site in the same geographic target area, the group assignment will be produced upon entry of individually-identifying information. If a community-dwelling beneficiary completes a subsequent health-related social needs screening at any time during the model, the community-dwelling beneficiary shall retain the intervention or control group assignment to which they were assigned after completing the initial health-related social needs screening.

The data collection system will risk stratify and randomize all community-dwelling beneficiaries as demonstrated in the track specific evaluation diagrams. The data collection system will also maintain the number of times the community-dwelling beneficiary has completed the health-related social needs screening, community-dwelling beneficiary responses to the health-related social needs screening, and whether or not the community-dwelling beneficiary received a tailored community referral summary and/or community navigation services.

Community Resource Inventory

The community resource inventory must include community service providers that can address the health-related social needs that are assessed in the screening tool. At a minimum, this inventory must include relevant resources listed in the local Continuum of Care and 2-1-1 systems, where available, and Eldercare.gov. If a No Wrong Door system is operational in the region, applicants must describe in the application how they will work with this system.

The community resource inventory must also include, with respect to each community service provider, the provider's contact information (i.e., telephone numbers, addresses, website, and email, as applicable) and hours of operation. Bridge organizations will be required to update this inventory at least every six (6) months. Applicants must demonstrate their ability to develop and maintain a community resource inventory. When preparing their application, applicants should consider the following:

- Existing community data sources that will be used to populate the community resource inventory;
- New community data sources necessary to address core and supplemental health-related social needs that may arise during the model intervention period as applicable;
- The applicant's current level of engagement with community service providers, including No Wrong Door (NWD) organizations and Medicaid health homes; and
- How the community resource inventory will be developed and maintained throughout the performance period.

Tailored Community Referral Summary

During the clinical visit (where a community-dwelling beneficiary is seeking care), bridge organizations, directly or through arrangements with a clinical delivery site or other third party, must offer all screened community-dwelling beneficiaries a tailored community referral summary of community service providers that might be able to address each of the health-related social needs identified through the screening. The tailored community referral summary must include contact information (i.e., telephone numbers, addresses, website, and email, as applicable) and hours of operation for each community service provider that may be able to address the identified health-related social needs. Bridge organizations must maintain and submit to CMS or its contractors a record of when community-dwelling beneficiaries were offered the tailored community referral summary as well as a copy of the summary. In all tracks, the bridge organization must screen and offer the tailored community referral summary, at a minimum, once every 12 months, but may screen and offer the summary more frequently.

In the Track 1 – Awareness intervention, only community-dwelling beneficiaries with a health-related social need *who are assigned to the intervention group* will be offered a tailored community referral summary. For Track 2 – Assistance and Track 3 – Alignment, all community-dwelling beneficiaries who screen positive for at least one health-related social need will be offered a tailored community referral summary.

With regards to the tailored community referral summary, applications to all tracks must include:

- A plan describing how the bridge organization will offer and distribute tailored community referral summaries to community-dwelling beneficiaries who screen positive for at least one health-related social need; and
- A plan describing how the bridge organization will review the tailored community referral summary with the community-dwelling beneficiary to ensure that the community-dwelling beneficiary understands what resources are available within the community to address the identified health-related social needs.

Learning System

To support shared learning and continuous quality improvement (QI) by bridge organizations, other model participants and CMS, CMS will create a learning system. The goal of the learning system will be to facilitate the sharing of information and promising practices among bridge organizations and other model participants. This all-teach, all-learn paradigm will encourage and support award recipients to improve upon their interventions throughout the duration of the model. Moreover, this learning system will be designed to assure that data-driven decisions are being made that can accelerate and optimize the desired outcomes of the model.

Award recipients will be required to participate in learning system activities. CMS will use various approaches to group learning and information exchange to assist award recipients with effectively sharing their experiences, tracking their progress, and rapidly adopting new ways of achieving improvement in the AHC model. CMS will require, as a condition of award, bridge organizations and other model participants to work with the learning system program to:

- Engage in results-driven learning;
- Create a driver diagram as a framework to guide and align intervention design and implementation activities;
- Provide data and feedback to CMS to: (1) assure that their learning and improvement needs are being met and (2) contribute to the creation of a collection of promising practices;
- Provide understanding of state and federal programs that complement AHC-like interventions in the communities they serve;
- Develop, track and report on quality improvement efforts, activities, and measures, at regular intervals;
- Align data-driven decisions with the successful outcomes sought by the AHC model; and
- Participate in learning system events in-person (lasting approximately two days) and virtually (i.e., web series, online seminars, and teleconferences).

Implementation Plan

Applicants must submit a detailed implementation plan, with the application, that describes how the applicant intends to implement the track to which it is applying and: (1) implement the AHC intervention as intended, (2) achieve track-specific milestones, and (3) engage in program quality improvement. The implementation plan, submitted with the application, should include:

- A detailed work plan that includes milestones, dates and task owners for the start-up period;
- A high-level work plan outlining milestones, dates and task owners for the duration of the period of performance;
- A narrative and diagram of the proposed organizational structure detailing relationships with model participants (i.e., state Medicaid agency, clinical delivery sites, and community service providers) and the flow of funds, data, and communications;
- Process descriptions for staff training and intervention rollout, which the applicant must further develop into standard operating procedures (SOPs) if awarded a cooperative agreement;
- Policies and procedures for screening and referral, community service navigation services, and integrator role functions (for detailed descriptions of each intervention, see Sections 2.4.1.2 Track 1 – Awareness Intervention Proposal Requirements, 2.4.1.3 Track 2- Assistance Intervention Proposal Requirements, and 2.4.1.4 Track 3 – Alignment Intervention Proposal Requirements);
- An assessment of risks to implementation and assumptions that may impact projected timelines, and mitigation strategies for reducing the probability of the risk occurring;
- The driver diagram, which serves as a framework for intervention design and implementation and establishes self-directed performance indicators for quality improvement;
- Assessments of program duplication; and
- A Health Resource Equity Statement (HRES) – see below.

CMS may request modification of the implementation plan after the award is made. During the startup period award recipients will be required to fully develop standard operating procedures. At minimum the implementation plan should be reviewed and updated annually. The CMS project officer will use the implementation plan to discuss and document the progress each award recipient is making throughout the performance period.

Health Resource Equity Statement

The Accountable Health Communities model will require a health resource equity statement for all award recipients. HRES is synonymous with what are called “Disparities Impact Statements.” The purpose of the HRES is to assist bridge organizations and other model participants with: (1) identifying and targeting minority and underserved populations (geographic and otherwise) in model participation; (2) assessing their total model in relation to these targeted subpopulations; (3) evaluating the inclusion of subpopulations in the AHC model; and (4) tracking progress on outcomes and engagement of these subpopulations throughout the AHC performance period. Applicants should develop the HRES and include it with their application. Each impact statement should include a statement of need, an action plan, and a performance assessment and data summary (see Appendix 8: Health Resource Equity Statement for template). Upon award, award recipients will be required to review, update, and report on their HRES every six months.

Assessment of Program Duplication

Applicants must conduct a detailed analysis of programs - including but not limited to those funded by Medicare and/or Medicaid, other federal agencies, and state and local governments, which coordinate community services for individuals, navigate these services, or otherwise could overlap with one of the model tracks. Applicants must submit along with their application an Assessment of Program Duplication (see Appendix 7: Assessment of Program Duplication for details) for each program identified as potentially duplicative. Applicants should use the list of potential overlap areas in Appendix 7 to compare existing programs to the AHC requirements and protocols as outlined in the FOA and identify overlaps and gaps.

Key Personnel

Applicants must detail their plan for the administration of the AHC model. Applicants must indicate the relevant titles and qualifications for bridge organization, state Medicaid agency, and clinical delivery site staff proposed as key personnel if awarded a cooperative agreement. Key personnel may be assigned to more than one functional area, but each individual's cumulative time may not exceed one Full-Time Equivalent (FTE). Applicants may propose other positions in addition to the key personnel noted in Table 2 and should propose an appropriate number of FTEs to meet program objectives. At a minimum, applications must account for the following key personnel:

Table 2. Key Personnel

Key Personnel	Primary Responsibilities	Other Requirements
Program Manager (All Tracks)	• Submission of the implementation plan to CMS and collaborating with CMS on revisions. • Coordination with model participants for intervention implementation. • Participation in and, as necessary, coordination with CMS. • Development and submission of all quarterly and annual progress reports. • Planning, overseeing, and submitting to CMS annual reports about potentially duplicative services. • Development, submission and revision of requested reports and documents required under this FOA or terms and conditions of award. • Data collection and submission for CMS monitoring and evaluation purposes. • Management and accountability for achieving AHC goals and milestones.	The licensing, credentialing, and education of the program manager is at the discretion of the bridge organization. CMS recommends the program manager as full-time personnel dedicated to the AHC effort.

Key Personnel	Primary Responsibilities	Other Requirements
Screening and Referral Specialist (All Tracks)	• Implementation of the screening and referral process. • Facilitation of the screening and referral process at clinical delivery sites. • Documentation and tracking of screening and referral services. • Data collection and reporting as required by CMS or its contractors.	The licensing, credentialing, and education of the screening and referral specialist is at the discretion of the bridge organization. The bridge organization should consider the organizational structure to assure that all eligible community-dwelling beneficiaries are offered screening and referrals in a timely manner.
State Medicaid Agency Staff (All Tracks)	• AHC data reporting. Submission of Medicaid claims-based outcome data required for model monitoring and evaluation. • Development of consortium within 12 months of award. • Annual review for alignment and overlap with existing Medicaid policy, waivers, and State Plan Amendments. • Program coordination and review every six months for scalability and sustainability planning. • Eight hours per month for advisory board and QI meetings and tasks. (Track 3 only).	
AHC Navigator(s) (Track 2 and 3)	• In-depth assessment and care coordination follow-up with community-dwelling beneficiaries until needs are resolved or documented as unresolvable. • Documentation and tracking of beneficiary-level navigation activities and outcomes, including: encounters, community-dwelling beneficiary contact attempts, preparation of person-centered action plans. • Data collection and reporting as required by CMS.	At a minimum, AHC navigators shall have functional knowledge in: prevalent health conditions, mental health disorders, substance use disorders, interviewing techniques, care planning, cultural competency, self-advocacy, self-direction, parent/family engagement, and community-specific resources.

Key Personnel	Primary Responsibilities	Other Requirements
QI Facilitator (Track 3 only)	• Develop QI plan. • Manage milestones. • Facilitate appropriate data sharing among model participants and advisory board. • Develop data sharing protocols and reporting schedules. • Prepare gap analysis and integrate areas of improvement into plan. • Develop QI strategy and establish QI priorities. • Collect and analyze QI measures. • Develop QI reports on progress which include qualitative and quantitative evidence of improvement, including but not limited to run-charts, PDSAs, and surveys. • Manage accountability of QI Plan task leads.	The licensing, credentialing, and education of the QI facilitator is at the discretion of the bridge organization.

2.4.1.1 Track 1 – Awareness Intervention Proposal Requirements

Track 1 – Awareness

Evidence supports the utility of screening and referral interventions to address unmet health-related social needs. For example, a cluster randomized controlled trial at eight urban community health centers (CHCs) demonstrated that systematically screening and referring for health-related social needs during well-child care visits can lead to the receipt of more community services by families.[18] Another study tested emergency department-based outreach and enrollment for the State Children's Health Insurance Program (SCHIP) in five geographically diverse emergency departments.[19] This study demonstrated that simply handing out Medicaid or SCHIP insurance applications to parents of uninsured children in the ED can nearly quadruple the baseline odds that these children will be enrolled in Medicaid or SCHIP.

The first approach of the AHC model will build upon this evidence and test whether increasing community-dwelling beneficiary *awareness* of available community services through information dissemination and referral impacts total health care costs and inpatient and outpatient health care utilization. This approach addresses the decreased capacity of clinical delivery sites to respond to community-dwelling beneficiaries' health-related social needs because (1) health-related social needs remain undetected due to the lack of universal screening and (2) clinical delivery sites and community-dwelling beneficiaries lack awareness about existing community service providers to address those needs.

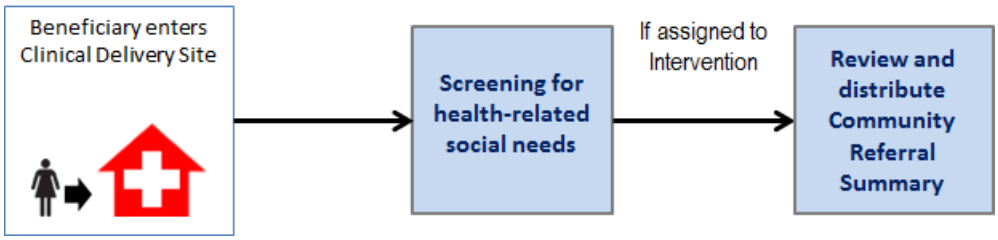

Figure 4. Track 1 – Awareness Intervention Pathway

The Track 1—Awareness intervention includes the following elements that will be performed either by the bridge organization directly, or by the bridge organization through an arrangement with clinical delivery sites or another third party:

1. **Offer screening for health-related social needs.** The bridge organization will offer screening for health-related social needs to all community-dwelling beneficiaries at the time they seek health care at the participating clinical delivery site.

   All community-dwelling beneficiaries who screen positive for one or more health-related social needs will be stratified based on their ED utilization history during the previous 12-month period and randomized to an intervention or control group. All community-dwelling beneficiaries who are randomized to the intervention group will be offered both usual care and the intervention. All community-dwelling beneficiaries in the control group will be offered only usual care.

2. **Prepare a tailored community referral summary.** During the clinical visit (when a community-dwelling beneficiary is seeking care), the bridge organization will match the community-dwelling beneficiary's identified health-related social needs with community service providers in the community resource inventory to create a tailored community referral summary for the community-dwelling beneficiary assigned to the intervention group. The tailored community referral summary must include information on how the community-dwelling beneficiary can contact each identified community service provider.

3. **Review the tailored community referral summary.** The bridge organization must offer to review a written copy of the tailored community referral summary with each community-dwelling beneficiary receiving the Track 1- Awareness intervention.

4. **Distribute a copy of the tailored community referral summary.** The bridge organizations must offer to each community-dwelling beneficiary in the intervention group a copy of the tailored community referral summary before the end of the community-dwelling beneficiary's appointment for clinical care at the clinical delivery site. Once the bridge organization has offered the tailored community referral summary, the Track 1 – Awareness intervention is complete.

Figure 5 depicts the Track 1 – Awareness intervention pathway and incorporates the stratified randomization evaluation pathway to illustrate how Track 1 treats both community-dwelling beneficiaries without a health-related social need and, for those who screen positive for a health-related social need, community-dwelling beneficiaries assigned to the intervention or control group.

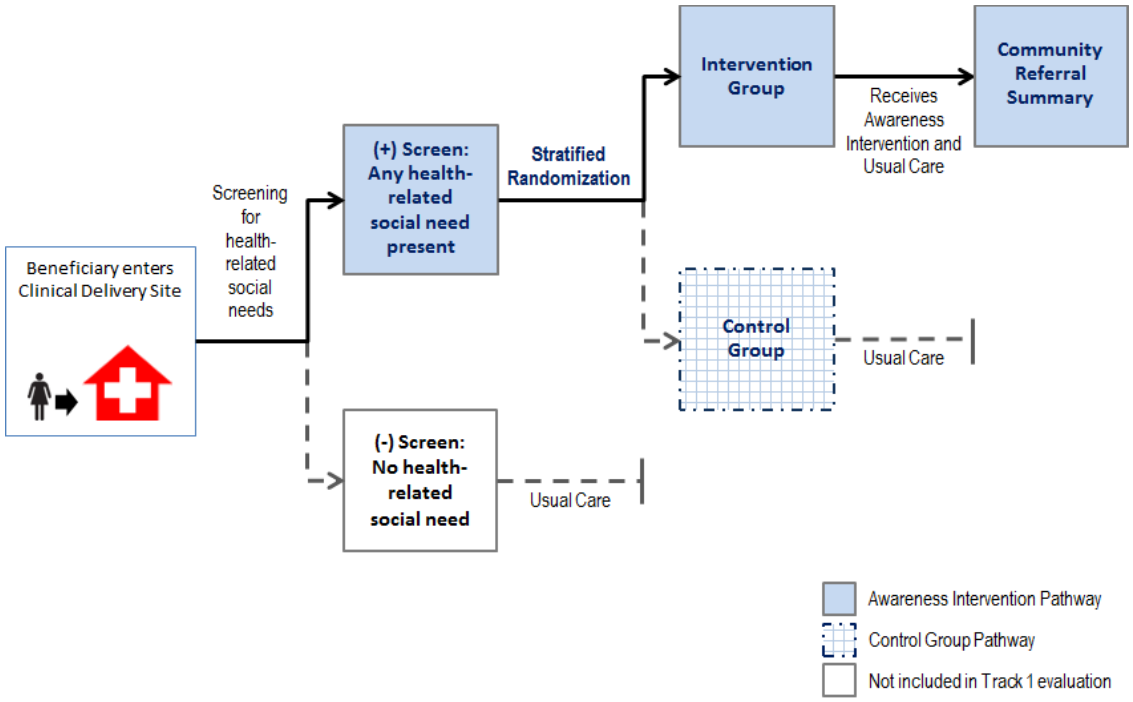

Figure 5. Track 1 – Awareness Evaluation Diagram

While bridge organizations within Track 1 – Awareness will have some flexibility in how they implement the core elements of this intervention, each proposal must specifically address:

- Each heading included in Section 2.4.1.1 - Model Test Proposal Requirements – All Tracks.
- *Model Participants.* The bridge organization must explain how it has an established and credible presence within the community (or how it intends to establish this presence during the start-up period), along with a successful track record of working across clinical delivery sites and community service providers (or how it intends to establish this during the performance period). Applicants must submit contracts, MOUs or MOU equivalents from at least one hospital, one primary care provider or practice, and one provider of behavioral health services evidencing their commitment to implementing the intervention (see Section 5.2 Application Structure and Content, Subsection on Contracts, MOUs or MOU Equivalents from Clinical Delivery Sites). Applicants may also submit optional contracts, MOUs or MOU equivalents from other organizations (e.g., local payers, county or state government, Indian tribes, foundations, certified community development financial institutions) and community service providers to demonstrate the commitment of the community to model implementation. The applicant must also submit a contract, MOU or MOU equivalent from at least one state Medicaid agency (see Section 5.2 Application Structure and Content, Subsection on Contract, MOU or MOU Equivalent from State Medicaid Agency).
- *Systematic screening*. The bridge organization must, directly or through arrangements with clinical delivery sites or another third party, offer screening for health-related social needs to all community-dwelling beneficiaries who seek care from participating clinical

delivery sites. Applicants must describe how this requirement will be achieved and the responsibilities of model participants in implementing this component of the intervention. Award recipients will be expected to report beneficiary-level responses to the screening tool.

- *Review of the tailored community referral summary*. The bridge organization must offer a copy of the tailored community referral summary to each community-dwelling beneficiary in the intervention group and describe its purpose, including how the community-dwelling beneficiary can contact the community service providers listed. CMS will require that a copy of each tailored community referral summary, including beneficiary identifiers, be reported to CMS, in a system and format specified by CMS. In the proposal, applicants must describe a plan for preparing, reviewing and distributing the tailored community referral summaries to all community-dwelling beneficiaries assigned to the intervention group.
- *Engagement with state Medicaid agency*. The application should clearly address the engagement of applicable state Medicaid agency/ies and their ability to provide Medicaid inpatient and outpatient health care utilization data to CMS through the traditional Medicaid claims submission process. The application must also describe a strategy for providing CMS and its contractors with timely access to beneficiary-level information on inpatient and outpatient utilization of community-dwelling Medicaid beneficiaries, in the absence of timely Medicaid claims data being available through the traditional claims submission process.

Evaluation Strategy

The evaluation of the Track 1 - Awareness intervention will include a detailed analysis of how the intervention has addressed community-dwelling beneficiary health-related social needs and the resulting impact on total health care costs and inpatient and outpatient health care utilization for high risk community-dwelling beneficiaries receiving the Track 1 intervention.

Community-dwelling beneficiaries with at least one health-related social need will be stratified based on ED utilization and randomized to either the intervention group, where they will be offered a tailored community referral summary and usual care, or to the control group, where they will be offered only usual care. CMS or its contractors will develop and maintain a system, accessible to the bridge organization, to notify the bridge organization of all community-dwelling beneficiaries' AHC enrollment status (i.e., intervention or control). Once a community-dwelling beneficiary is assigned to an intervention or a control group, they will remain in that group throughout the model. The bridge organization must utilize this tracking and reporting system to provide CMS with all results of the screening tool, including beneficiary identifiers, identified health-related social needs, and whether each community-dwelling beneficiary accepted or rejected the offer of the intervention. The bridge organization must also be responsive to CMS and its contractors regarding requests for site visits and other requested information.

Randomization within Track 1 will increase the likelihood that community-dwelling beneficiaries in the intervention and control groups are similar both in terms of their inpatient and outpatient health care utilization and their health-related social needs. This increases the likelihood of CMS accurately identifying the impact of the intervention. Bridge organizations

should not share with clinical delivery sites information on screening results and whether a community-dwelling beneficiary was assigned to the intervention or control group until after the community-dwelling beneficiary has completed his or her appointment so that the community-dwelling beneficiary's designation does not affect the provision of usual care during the appointment. Stratification based on reported ED utilization will help CMS to delineate between high and low risk intervention groups and further increase the ability to identify an impact of the intervention among subsets of the population.

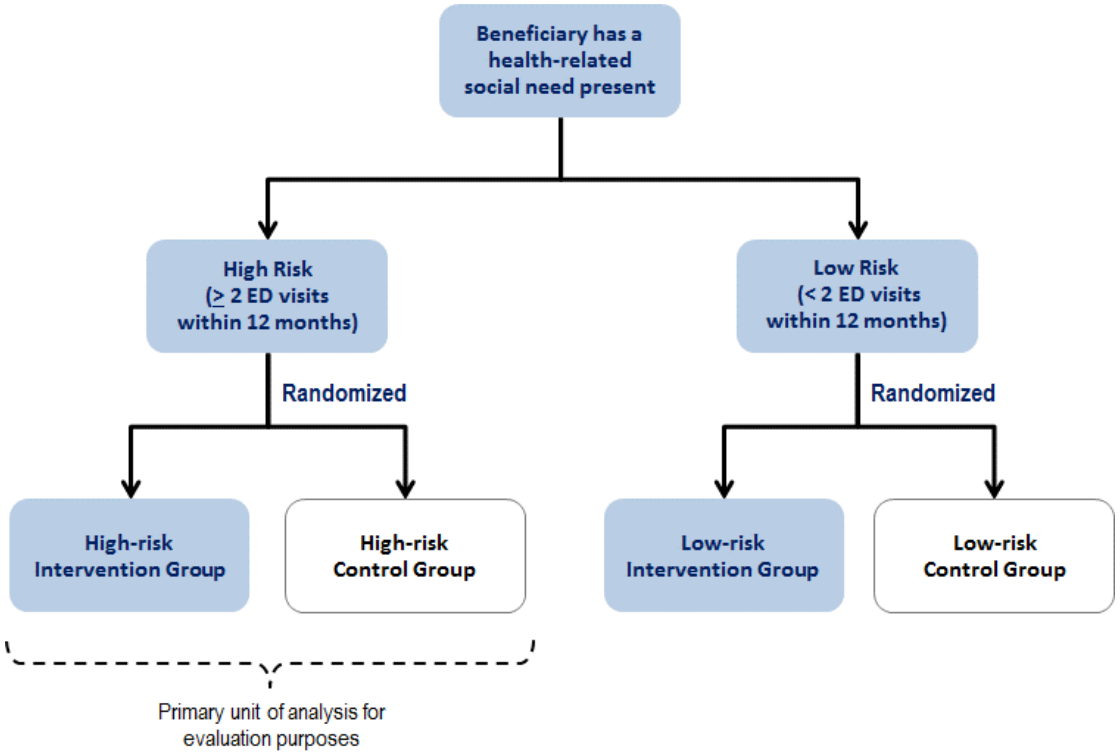

Figure 6. Stratified Randomization Process

Each community-dwelling beneficiary who seeks care from a participating clinical delivery site will be offered the screening, and the information that the bridge organization collects through the screening will be valuable for understanding baseline characteristics of all AHC model participants. This collected information will be critical in assessing the impact of the intervention as it will include beneficiary-reported ED utilization history and health-related social needs for both the intervention and control groups.

Milestones

CMS will monitor the performance of each award recipient based on milestones established by this funding opportunity, the Terms and Conditions of Award, and the implementation plan approved by CMS. Only those bridge organizations achieving pre-determined milestones may be recommended for a non-competing continuation award for subsequent budget periods.

Applicants will be expected to propose, as part of their implementation plan, process measures that can assess the activities carried out by the bridge organization and outcome measures that

assess the impact of those activities. These measures will be reviewed and approved by CMS and will become part of the metrics used to evaluate an award recipient's continued progress. See Table 3 for Track 1 – Awareness milestones and deliverables.

Table 3. Track 1 – Awareness Milestones and Deliverables

Milestones	Deliverable
Start-up by month 6	
Update implementation plan and SOPs detailing communication strategy with clinical delivery sites, screening and referral process, and data sharing and outcome reporting with CMS/contractors	Implementation Plan
Finalize screening tool	Screening tool
Complete Community Resource Inventory	Community Resource Inventory
Deploy tailored community referral summary system to participating clinical delivery sites	Implementation Plan
Train staff in conducting screening, or develop instructions for self-screening	Implementation Plan
Establish formal relationships with clinical delivery sites	Contract, MOU or MOU equivalent with each clinical delivery site
Year 1*	
Offer to screen 37,500 community-dwelling beneficiaries * Screening figures were calculated from the figures needed for treatment and then assuming 1:1 treatment-to-control ratio, 75% consent rate and 13% high risk rate community-dwelling beneficiaries.	Data submission to CMS or its contractors
Provide and review community referral summary with 1,828 community-dwelling beneficiaries	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter
Completion of contracts, MOUs and/or MOU equivalents establishing the consortium	Documentation of consortium arrangement between bridge organization and other model participants
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 2	
Offer to screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide and review community referral summary with 3,656 community-dwelling beneficiaries	Data submission to CMS or its contractors

Milestones	Deliverable
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 3	
Offer to screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractor
Provide and review community referral summary with 3,656 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups	Data submission to CMS or its contractors
Progress reports on milestones	Report submission after the completion of each quarter
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 4	
Offer to screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide and review community referral summary with 3,656 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs	Data submission to CMS or its contractors

Milestones	Deliverable
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the end of each quarter
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 5	
Offer to screen 37,500 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide and review community referral summary with 1,828 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan

2.4.1.2 **Track 2 – Assistance Intervention Proposal Requirements**

Track 2 – Assistance

Evidence supports that one-on-one support, usually from a case manager, community health worker, or other trained professional, can help community-dwelling beneficiaries gain access to community services and impact their inpatient and outpatient health care utilization. For example, the Health Leads program, a foundation-funded program that operates in the Boston, Mid-Atlantic, New York and Bay Areas, provides screening and short-term follow-up coordination for health-related social needs. Within 6 months of assessment, 50 percent of families had enrolled in at least one service. The most common needs were employment (25 percent), housing (14 percent), and child care (13 percent).[20] In another example, a 24-month randomized controlled trial of frequent ED users tested the effect of case management, including

assistance in obtaining stable housing and income entitlements, referral to substance abuse services when needed, and ongoing community outreach. Patients receiving case management had lower levels of homelessness, problem alcohol use, and unmet financial needs at follow-up. Patients receiving case management also had fewer numbers of ED visits and lower rates of inpatient admissions than usual care patients. [21]

The second track of the AHC model will build upon this evidence and test whether assisting high-risk community-dwelling beneficiaries with accessing community services through community service navigation impacts total health care costs and inpatient and outpatient health care utilization. High-risk community-dwelling beneficiaries may need assistance overcoming barriers to resolving those needs; simply having a referral may not be enough for these patients. This intervention incorporates innovations from Track 1 (universal screening for health-related social needs and use of a community resource inventory to connect community-dwelling beneficiaries to available community services) with two additional features: (1) identifying high-risk community-dwelling beneficiaries as part of a smarter spending strategy to target additional resources where they are needed the most; and (2) community service navigation to assist high-risk community-dwelling beneficiaries with resolving health-related social needs.

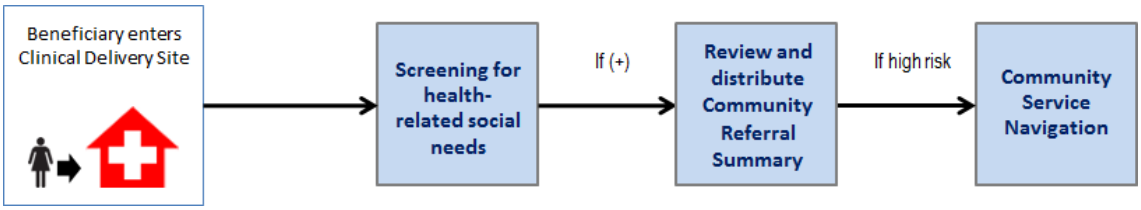

Figure 7. Track 2 – Assistance Intervention Pathway

Track 2 – Assistance intervention includes all of the Track 1 – Awareness intervention components described above. In Track 2, however, the tailored community referral summary is offered to all community-dwelling beneficiaries who screen positive for one or more health-related social needs. Track 2 also includes the following components:

(1) **Identify high-risk community-dwelling beneficiaries.** Risk stratification of all community-dwelling beneficiaries will occur based on their reported ED utilization history. High-risk community-dwelling beneficiaries will be randomized to the intervention group or control group.

(2) **Offer navigation services.** In addition to usual care and the Awareness intervention described in Track 1, high-risk community-dwelling beneficiaries in the Track 2 intervention group will be offered navigation services. Navigation services include: an in-depth personal interview, development of a person centered action plan, AHC navigator follow-up services, and documentation of encounters with each community-dwelling beneficiary receiving navigation services.

Track 2 – Assistance uses a randomized design to test whether *assisting* high-risk community-dwelling beneficiaries with accessing community services through community service navigation impacts total health care cost and inpatient and outpatient health care utilization. Figure 8 depicts the Track 2 – Assistance intervention pathway and incorporates the evaluation design to illustrate the intervention and evaluation pathways for community-dwelling beneficiaries assigned to the intervention group, control group, or non-enrolled group.

Bridge organizations, either directly or through arrangements with clinical delivery sites or a third party will screen all community-dwelling beneficiaries who seek care at participating clinical delivery sites for health-related social needs. All community-dwelling beneficiaries who report at least one health-related social need on the screening tool, but report less than 2 ED visits in the 12 month period immediately prior to the clinical care appointment at the clinical delivery site (low-risk) will be offered a tailored community referral summary and usual care (the Track 1 – Awareness intervention).

All community-dwelling beneficiaries who report at least one health-related social need and 2 or more ED visits in the 12 month period immediately prior to the clinical care appointment at the clinical delivery site (high-risk) will be randomized to either be offered community service navigation, a tailored community referral summary and usual care (the Track 2 – Assistance intervention) or only a tailored community referral summary and usual care (the Track 1 – Awareness intervention).

All community-dwelling beneficiaries who do not report at least one health-related social need on the screening tool (i.e., non-intervention group) will not be included in the model and will be offered usual care.

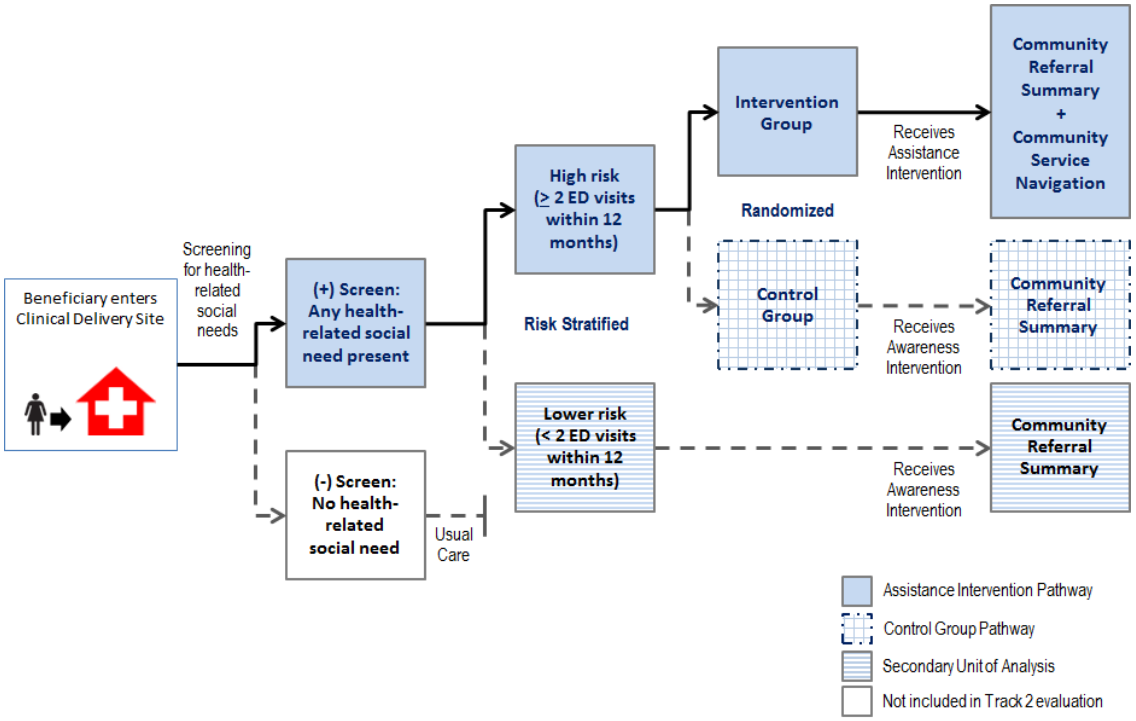

Figure 8. Track 2 – Assistance Evaluation Diagram

While bridge organizations within AHC Track 2 – Assistance will have some flexibility in how they implement the core elements of this intervention, each proposal must specifically address:

- Each heading included in Section 2.4.1.1 – Model Test Proposal Requirements – All Tracks.
- *Model Participants, Systematic Screening, Review of tailored community referral summary* and *Engagement with state Medicaid agency* intervention components detailed

in Section 2.4.1.2 Track 1 – Awareness Intervention Proposal Requirements; and each additional intervention component detailed below.

- *Risk Stratification.* All community-dwelling beneficiaries who report at least one health-related social need will be risk-stratified into two categories based on their ED utilization. High-risk community-dwelling beneficiaries will be randomized into either the intervention group (being offered tailored community referral summary and community service navigation in addition to usual care) or a control group (being offered a tailored community referral summary and usual care). Low-risk community-dwelling beneficiaries will receive a tailored community referral summary and usual care.
- *Community Service Navigation Service.* High-risk community-dwelling beneficiaries in the intervention group will be offered navigation services that might assist them in resolving health-related social needs that have been identified. The community service navigation service should be provided, on an individual basis, to the high-risk community-dwelling beneficiary by the AHC navigator. The navigation intervention may be repeated annually if the high risk community-dwelling beneficiary screens as having any health-related social need at least 12 months after previously being offered community service navigation services. Each provision of community service navigation services and its related outcomes must be reported to CMS. Applicants must describe in their proposal how the following community service navigation services will be implemented:
    a. **Conduct a Personal Interview.** AHC navigators will conduct an in-depth personal interview related to the core and supplemental health-related social needs (see Appendix 5: Domains of Health-Related Social Needs) identified in the screening. This personal interview should attempt to identify barriers to resolving these health-related social needs that may be faced by an individual community-dwelling beneficiary. The personal interview must take place no later than two business days after the community-dwelling beneficiary has been screened. AHC navigators are encouraged, but not required, to conduct the personal interview at the clinical delivery site. The bridge organization will be responsible for developing the tool that the AHC navigator will use to conduct the personal interview, the implementation process, and staff training. CMS will approve the interview tool, implementation process and staff training curriculum or methodology. Metrics for monitoring and evaluating the implementation of the personal interview will be agreed upon and approved by CMS after awards are made.
    b. **Develop an Action Plan**. At the end of the assessment, the AHC navigator will offer to develop an individualized action plan for the community-dwelling beneficiary. The action plan must include the community-dwelling beneficiary's goals and preferences, the results of the screening tool and personal interview, and a plan for how the community-dwelling beneficiary can overcome the barriers to accessing community services that may be able to address his or her health-related social needs. With the approval of the community-dwelling beneficiary, the action plan may be shared with the community-dwelling beneficiary's clinical providers and community service providers, consistent with federal, state, and local law. The bridge organization will be responsible for developing the format of the

action plan, implementing a process for AHC navigator/beneficiary action plan completion, and defining a staff training plan. CMS will approve the action plan format, implementation process and staff training curriculum/methodology (or curriculum model if implementing a structured assessment curriculum). Metrics for monitoring and evaluating the action plan will be agreed upon and approved by CMS after awards are made.

c. **Perform Follow-up**. Ongoing follow-up services will assist high-risk community-dwelling beneficiaries in accessing services to resolve unmet health-related social needs. Such follow-up services should be based on established best practices and may include, but are not limited to the following: telephone or text messaging contacts, home visits, making appointments with community service providers, and assisting clients with applying for services. Generally, initial follow-up should occur within two weeks of the date that the community-dwelling beneficiary accepts the action plan and should continue at least monthly thereafter until the high-risk community-dwelling beneficiary has been connected with a community service provider to meet each documented health-related social need or one or more of their health-related social needs is documented as unresolvable. An AHC navigator may note that a health-related social need is unresolvable if: (1) the community service to address the health-related social need is unavailable (e.g., a waiting list for housing) for more than six months; or (2) the AHC navigator has attempted to address the health-related social need with the community-dwelling beneficiary on at least three separate occasions with no resolution (e.g., the community-dwelling beneficiary is not responsive). AHC navigators will be required to report a status update on each of the health-related social needs identified in the action plan at six months following the date of the action plan or at the end of the five-year performance period (whichever comes first). CMS will approve the follow-up process provided in the bridge organization's implementation plan. CMS will also approve monitoring and evaluation metrics collected on follow-up services that are described in the bridge organization's implementation plan after awards made.

d. **Collect Data and Document Each Navigation Encounter**. Award recipients will be required to provide CMS and its contractors with an identifiable documentation record for each high-risk community-dwelling beneficiary who accepts the intervention. Award recipients will also be required to provide CMS and its contractors with outcome and process data related to community service navigation, including the action plan for addressing the identified need(s) and the outcome of the interactions with the community-dwelling beneficiary, including referrals made, referrals completed, and the status of the health-related social need(s). A referral will be deemed completed once the AHC navigator has documented communication between the community-dwelling beneficiary and the community service provider, whether face-to-face, telephonic or electronic, about whether the community service provider may be able to address the health-related social need(s) for which the community-dwelling beneficiary was referred. CMS will provide further guidance on these reporting expectations after awards are made.

- Whether community service navigation services are provided directly by the bridge organization or by the bridge organization through an arrangement with the clinical delivery site or a third party, it is the bridge organization's responsibility to ensure that the AHC navigator undergoes sufficient training to deliver the intervention. Applicants will be required to describe in their application a plan for oversight of AHC navigators and a schedule for refresher training. The Applicant should describe the desired education, credentials, and experience for the community service AHC navigator in in its budget narrative. Additionally, it is the bridge organization's responsibility to ensure that AHC navigators provide navigation services consistently across participating clinical delivery sites and record data appropriately. Lastly, bridge organizations must ensure that community service navigation is provided in a manner that is culturally and linguistically appropriate.

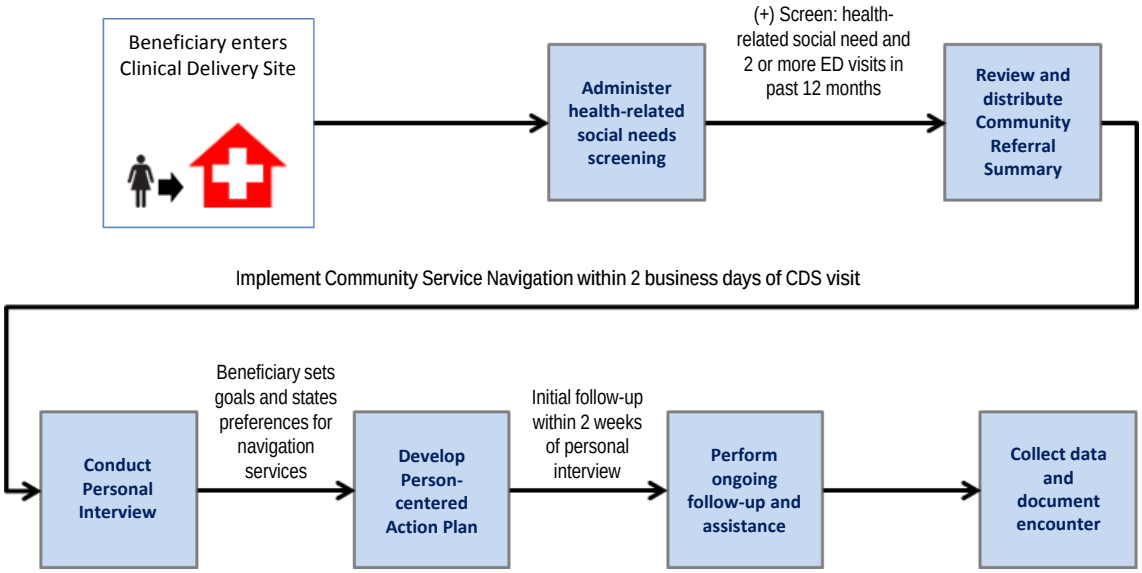

Figure 9. Community Service Navigation Process

Figure 9 depicts the community service navigation process.

Evaluation Strategy

The evaluation of the Track 2 – Assistance intervention will include a detailed analysis of how the intervention impacts total health care costs and inpatient and outpatient health care utilization through the resolution of identified health-related social needs among high-risk community-dwelling beneficiaries.

Analyzing Medicaid data related to total health care costs and inpatient and outpatient healthcare utilization is a cornerstone of the AHC evaluation. As such, the applicant's proposal should clearly address the intended engagement of applicable state Medicaid agency/ies and the ability of that/those agencies to timely submit Medicaid utilization data on ED visits and inpatient admissions through the usual claims submission process. The bridge organization must also propose a plan to provide CMS and its contractors with direct access to such utilization

information for participating community-dwelling Medicaid beneficiaries in the event the usual claims submission processes will not result in timely Medicaid claims data.

The bridge organization is required to offer screening to all community-dwelling beneficiaries who seek health services at a participating clinical delivery site. Those community-dwelling beneficiaries who self-identify on the screening tool as having at least two ED visits within the past year and at least one unmet health-related social need will be assessed as being "high-risk" and will be randomized into an intervention or control group. The intervention group will be offered usual care, a tailored community referral summary, and community service navigation while the control group will be offered usual care and a tailored community referral summary. The bridge organization must provide CMS and its contractors with a copy of the screening results for all screened community-dwelling beneficiaries, including beneficiary identifiers, whether the community-dwelling beneficiaries were randomized to the intervention or control groups, and whether those community-dwelling beneficiaries who were randomized to the intervention group accepted the tailored community referral summary and/or community navigation services.

In addition, the evaluation of Track 2 – Assistance will use descriptive statistics in an attempt to understand any change over time within the low-risk group - those community-dwelling beneficiaries who screen positive on the screening tool for one or more health-related social needs but who report less than two ED visits in the 12-month period prior to seeking clinical care at the clinical delivery site. CMS will use the information provided through the screening and methods such as follow-up surveys and calls in an attempt to determine if identified health-related social needs were resolved for participating community-dwelling beneficiaries. Identifying information for these low-risk community-dwelling beneficiaries will be linked to Medicare and Medicaid claims data, and CMS will assess their use of Medicare and Medicaid covered services both prior to and after receipt of the tailored community referral summary.

Milestones

CMS will monitor the performance of each award recipient based on milestones established by this funding opportunity, Terms and Conditions of Award, and the implementation plan approved by CMS. Only those bridge organizations achieving pre-determined milestones may be recommended for a non-competing continuation award for subsequent budget periods.

Applicants will be expected to propose, in their implementation plan, process measures that assess the activities carried out by the bridge organization and outcome measures that assess the impact of those activities. These measures will be reviewed and approved by CMS after awards are made and will become part of the metrics used to evaluate an award recipient's continued progress. See Table 4 for Track 2 – Assistance milestones and deliverables.

Table 4. Track 2 – Assistance Milestones and Deliverables

Milestones	Deliverable
Start-up by month 9	
Update implementation plan and SOPs detailing communication strategy with clinical delivery sites, screening and referral process, and data sharing and outcome reporting with CMS/contractors	Implementation Plan

Milestones	Deliverable
Finalize screening tool	Screening tool
Complete Community Resource Inventory	Community Resource Inventory
Train staff in conducting screening or instructions have been developed for self-screening	Implementation Plan
Deploy tailored community referral summary to participating sites	Implementation Plan
Train AHC navigator(s)	Training curriculum for AHC navigators
Deploy AHC navigators to participating sites	Implementation Plan
Complete contract, MOU or MOU equivalent with model participants establishing the consortium	Documentation of consortium arrangement between bridge organization and participating entities
Establish formal relationships with clinical delivery sites	Contract, MOU or MOU equivalent with each clinical delivery site
Year 1*	
Offer to screen 18,750 community-dwelling beneficiaries *Screening figures were calculated from the figures needed for treatment and then assuming a 40% participation rate in navigation services, 7:3 treatment-to-control ratio, 75% consent rate and 13% high risk rate among community-dwelling beneficiaries.	Data submission to CMS or its contractors
Provide tailored community referral summary and navigation services to 512 community-dwelling beneficiaries	Data submission to CMS or its contractors
Submitted progress reports on milestones	Report submission after the completion of each quarter
Completion of contracts, MOUs and/or MOU equivalents establishing the consortium	Documentation of consortium arrangement between bridge organization and other model participants
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 2	
Offer to screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide navigation services to 2,048 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs screening	Data submission to CMS or its contractors
Complete refresher training for AHC navigators	Report submission after the completion

Milestones	Deliverable
	of each quarter
Submit outcomes (referrals made, referrals completed, and status of health-related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups (at the discretion of CMS)	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 3	
Offer to screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide navigation services to 2,048 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs screenings	Data submission to CMS or its contractors
Completed refresher training for AHC navigators	Report submission after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health –related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups (at the discretion of CMS)	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter
Submit update to Implementation plan and assessment for program duplication	Implementation Plan
Year 4	
Screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors

Milestones	Deliverable
Provide navigation services to 2,048 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs screenings	Data submission to CMS or its contractors
Refresher training for AHC navigators	Report submission after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health –related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit Medicaid utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups	Data submission to CMS or its contractors
Progress reports on milestones	Report submission after the completion of each quarter
Submit update to Implementation plan and updated assessment for program duplication	Implementation Plan
Year 5	
Offer to screen 37,500 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide navigation services to 1,024 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs screenings	Data submission to CMS or its contractors
Complete refresher training for AHC navigators	Report submission after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health –related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter

Milestones	Deliverable
Submit update to Implementation plan and assessment for program duplication	Implementation Plan

2.4.1.3 Track 3 – Alignment Intervention Proposal Requirements

Track 3 – Alignment

Investments supporting integration between health care and community services can yield a positive return on investment when they build on a coordinating mechanism that supports informed community input and data sharing tools to support continuous quality improvement across multiple sectors.[22,23] For example, one organization has utilized a governance structure to facilitate collaboration across multiple organizations with a focus on decreasing hospital admissions and ED visits in a Medicaid population. This organization also uses robust data platforms that provide a report that allow providers, care coordinators, and community service providers to track a beneficiary's ongoing service utilization and outstanding needs. Results have shown significant decreases in ED visits and increases in quality of care, with more beneficiaries receiving optimal care across multiple chronic conditions, including diabetes, vascular conditions, and asthma.[24]

The final approach tested in the AHC model will determine whether a combination of community service referrals and navigation at the community-dwelling beneficiary level as well as model participant *alignment* at the community level impacts total health care costs and inpatient and outpatient health care utilization. This approach recognizes that there are significant barriers to effective integration of health care delivery systems and community services due to different organizational cultures, funding streams, and data systems. Appropriate infrastructure is needed to ensure that community services are available and responsive to the needs of all community-dwelling beneficiaries. This intervention incorporates the components of both Tracks 1 and 2 **and** adds structural supports and financial sustainability planning designed to foster community-wide realignment of resources to more effectively address health-related social needs for all community-dwelling beneficiaries.

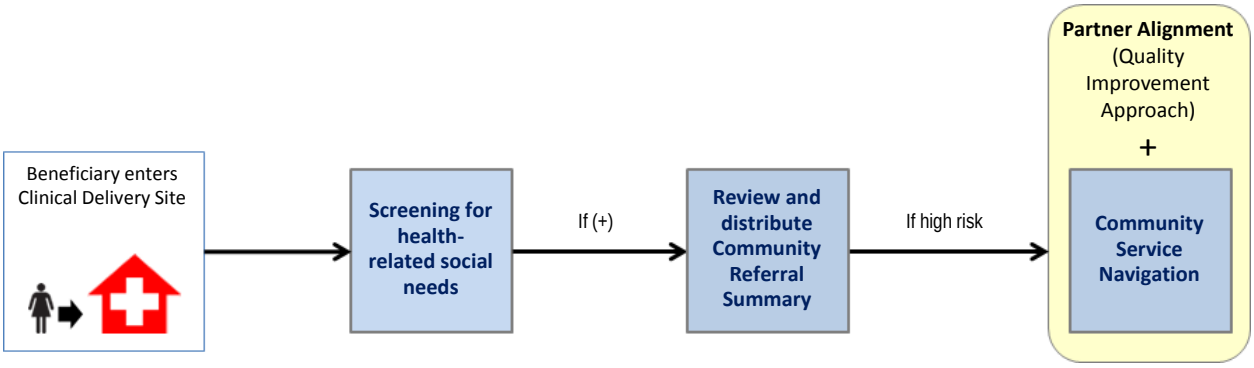

Figure 10. Track 3 – Alignment Intervention Pathway

Track 3 – Alignment intervention includes Track 1 – Awareness and Track 2 - Assistance intervention components described above. As in Track 2, all community-dwelling beneficiaries

who screen positive for one or more health-related social needs will be offered a tailored community referral summary in addition to usual care. However, in Track 3 all high-risk community-dwelling beneficiaries will be offered navigation services in addition to both a tailored community referral summary and usual care because high-risk community-dwelling beneficiaries in Track 3 are not randomized. In addition, the bridge organization in Track 3 shall implement a community-level quality improvement approach by assuming certain Integrator functions (see Section 2.4.1.4 Track 3 – Alignment Intervention Proposal Requirements, Subsection on Integrator Role for details) in the geographic target area that it has identified (see Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Geographic Target Area and Percent Capture of Community-Dwelling Beneficiaries for details).

The evaluation of the Track 3 Alignment intervention will include a detailed analysis of how the intervention impacts the resolution of identified health-related social needs, total health care costs and inpatient and outpatient health care utilization both at the overall community-level and at the beneficiary-level. Figure 11 depicts the Track 3 – Alignment evaluation diagram and incorporates the evaluation design to illustrate the intervention and evaluation pathways for all community-dwelling beneficiaries assigned to the intervention groups or not included in the Track 3 – Alignment Evaluation.

Bridge organizations, either directly or through arrangements with clinical delivery sites or a third party, will offer screening to all community-dwelling beneficiaries who seek care at participating clinical delivery sites for health-related social needs. All community-dwelling beneficiaries who screen as being at low-risk will be offered a tailored community referral summary in addition to usual care (the Track 1 – Awareness intervention).

All community-dwelling beneficiaries who report at least one health-related social need and 2 or more ED visits in the 12-month period immediately prior to the clinical site visit will be assigned to the intervention group. All community-dwelling beneficiaries in the intervention group will be offered community service navigation, a tailored community referral summary (the Track 2 – Assistance intervention) and usual care.

All community-dwelling beneficiaries who do not have a health-related social need will not be included in the intervention and will be offered usual care.

Track 3 – Alignment adds a quality improvement (QI) element to the Track 2 –Assistance Intervention; which requires the bridge organization to serve in an integrator role. The Track 3 – Alignment QI approach requires bridge organizations to (1) define the geographic area of interest to focus community-level efforts; (2) perform an annual gap analysis of the community's needs and available resources; (3) convene an advisory board that can assess and prioritize community-dwelling beneficiary and community needs; and (4) create and implement a quality improvement plan to address identified needs. Bridge organizations will be required to develop a data infrastructure that permits model participants to understand the health-related social needs of the community-dwelling beneficiary population and develop and implement a QI plan that improves system efficiency. This approach recognizes that there are significant barriers to effective integration of health care delivery systems and community services due to different cultures, funding streams, and data systems.

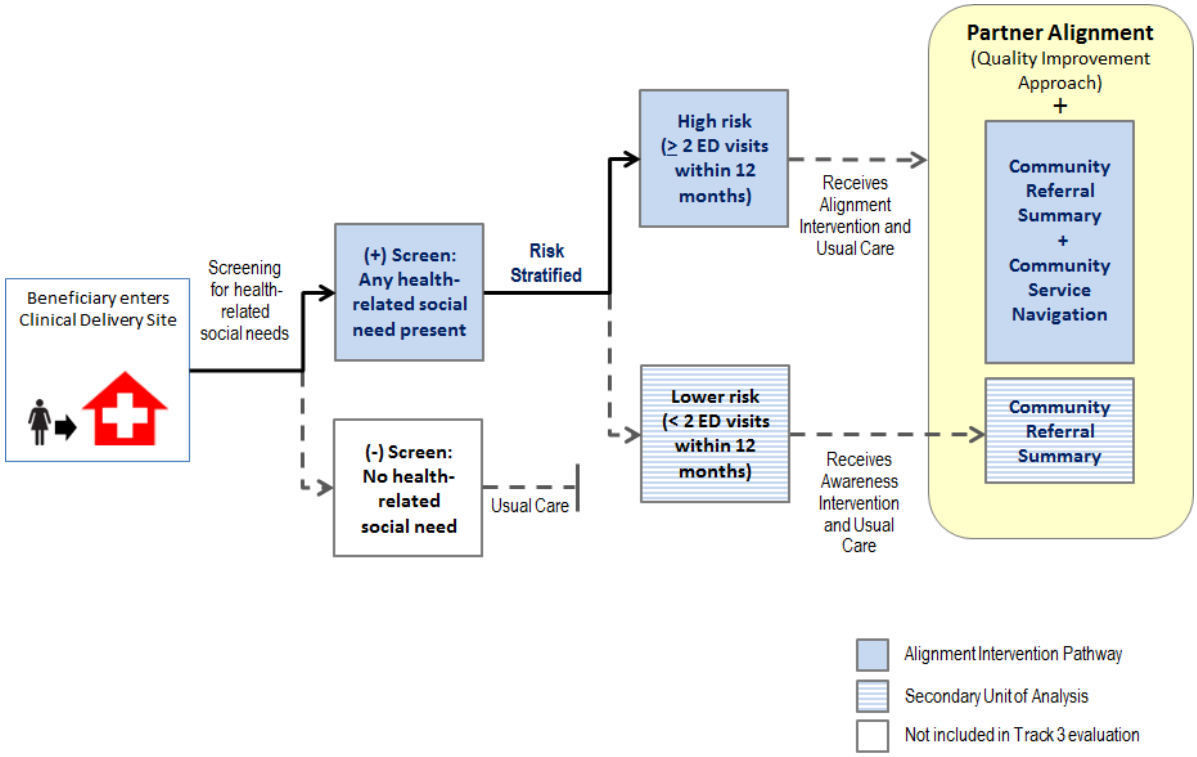

Figure 11. Track 3 – Alignment Evaluation Diagram

While bridge organizations within the Track 3 – Alignment Intervention have some flexibility in how they implement the core elements of this intervention in collaboration with clinical delivery sites and other model participants, each proposal must specifically address:

- Each heading included in Section 2.4.1.1 – Model Test Proposal Requirements – All Tracks.
- All proposal requirements as detailed in Section 2.4.1.2 Track 1 – Awareness Intervention subsections and proposal requirements as detailed in Section 2.4.1.3 Track 2 – Assistance Intervention Subsection: *Community Service Navigation.*
- *Risk-Stratification.* All community-dwelling beneficiaries with a health-related social need will be risk-stratified into two categories. High-risk community-dwelling beneficiaries will receive tailored community referral summary and community service navigation in addition to usual care. Low-risk community-dwelling beneficiaries will receive a tailored community referral summary in addition to usual care.
- *Integrator Role*. In Track 3 – Alignment, bridge organizations will receive additional funding to assume the role of an integrator to promote enchanced coordination and continuous quality improvement. Bridge organizations in Track 3 – Alignment will assume the following role and functions:
  - **Advisory Board Convener:** All bridge organizations in Track 3 – Alignment must establish an advisory board that convenes at least quarterly and includes representatives from: state Medicaid agency(ies); local government(s) (e.g., Department of Public Health, Mayor's office); all participating clinical delivery sites;

participating community service providers (i.e., community service providers for each health-related social need identified by the health-related social need screening tool); local health and community service payers and providers; and beneficiaries and their caregivers. The application must describe how the advisory board will assess and prioritize stakeholder and community needs, assist the bridge organization in preparing the annual gap analysis, and support the development of a QI plan. Applicants must provide in their applications a list of proposed advisory board participants and contracts, MOUs or MOU equivalents with each proposed participant that states their commitment to and intended role on the advisory board. After award, award recipients shall submit information describing the structure of the advisory board meetings and its core functions and processes for achieving the AHC program goals. At a minimum, award recipients must provide the following information: purpose statement for the advisory board, board membership, planned and actual meeting details (e.g., frequency, notice, governance to conduct meetings, quorum, etc.), accountability processes, and reports. CMS encourages advisory board transparency and will evaluate the applicant's ability to implement an advisory board that supports community engagement. CMS will review and approve the advisory board implementation plan after awards are made.

- **Data Sharing:** An interoperable health IT ecosystem can serve as a foundation for managing community investments. Health IT can make the right health data available to the right people at the right time across multiple organizations in a way that can be meaningfully used. It can allow providers, community-dwelling beneficiaries and their families, public health entities, and community service providers to electronically collect, share, and use health information to achieve better care, healthier people, and smarter spending. CMS recognizes that communities vary in the level of IT interoperability between clinical delivery sites and the extent to which bidirectional data sharing with community service providers occurs.

  The application must describe how the applicant (upon award) will use data-driven decision-making for determining resource allocation and measuring the success of the intervention or specific components of the intervention, while emphasizing the importance of structured data capture and of standards-based exchange. CMS will require bridge organizations to collect and report (or have participants in their consortia collect and report) identifiable beneficiary-level data (i.e., PII-Personally Identifiable Information), including data from clinical delivery sites and community service providers, using standards, where supportable, and report, as required, to CMS and its contractors in a secure manner. Bridge organizations must also share patient de-identified information with the advisory board; each applicant must have a legally defensible means of sharing patient de-identified data on participating community-dwelling beneficiaries' health-related social needs with the advisory board. Bridge organizations must be able to demonstrate how they will ensure the flow of any relevant data from clinical delivery sites and its AHC navigators to CMS and its contractors for monitoring and evaluation purposes, including how it or the consortium members will track outcomes of navigation services at the beneficiary level. Outcomes include referrals made, referrals completed, and health-related social needs resolved. Applicants must describe plans for tracking and reporting (or securing consortium members' tracking and reporting) on each community-dwelling

beneficiary's service use and costs across all care settings pertinent to the AHC model, including community services.

- **Gap Analysis:** A unique feature of the Track 3 – Alignment Intervention is that it requires award recipients and the model participants to utilize the data sharing infrastructure to facilitate continuous quality improvement across multiple sectors. Track 3 – Alignment, QI includes an analysis of the extent to which available community services adequately address the health-related social needs of high-risk community-dwelling beneficiaries. Based on the systematic collection of data on referral completion rates and resolution of health-related social needs, the bridge organization will conduct a gap analysis at least annually and produce a QI plan for community level adjustments to improve community-dwelling beneficiaries' access to and availability of community resources. A gap analysis is the comparison of actual performance with potential or desired performance, thus revealing areas for improvement, including barriers that are limiting referral completion rates and impeding resolution of health-related social needs. To support population health efforts, bridge organizations may supplement data in the gap analysis with quantitative and qualitative data from other sources (e.g., community health needs assessment and length of wait lists among community service providers). The applicant must describe the bridge organization's ability to conduct a gap analysis with assistance from the advisory board. The applicant must also describe current efforts, if any, in the geographic target area to assess community health-related needs, identify areas for improvement, and implement strategies for addressing identified needs.
- **Quality Improvement Plan:** Bridge organizations will be responsible for collaborating with the advisory board to develop QI plan and update annually based on the gap analysis. The QI plan will serve as a guidance document for the bridge organization and other model participants as they implement the model. The QI plan will describe how activities that address gaps in community services will be managed, deployed, and reviewed by the award recipient and the advisory board and coordinated with other model participants. The QI plan will help determine whether Track 3 – Alignment related efforts have been successful in achieving stated goals.

  Applicants must address the following components of the QI plan in their proposal:

  - Goals. Describe what is to be accomplished over a defined time frame. There should be a clear mission statement that community stakeholders can relate to in their own organizational activities.
  - Plan Management and Monitoring. Describe how the bridge organization will manage and monitor the QI plan, including roles and responsibilities of model participants, any outcome metrics, and coordination of QI activities with the advisory board and model participants. The QI plan must describe the process for selecting quality improvement projects and team leaders. The QI plan must also contain a sustainability plan for the Track 3 – Alignment community. Bridge organizations will be responsible for monitoring data monthly to assess progress and inform continuous QI in addressing gaps and achieving milestones detailed in the QI plan.

- QI Methodology. Describe the quality tools and techniques (e.g., Plan-Do-Study-Act cycles, run charts, etc.) to be utilized by the bridge organization and advisory board.
- Communications. Describe how updates to planned QI activities and processes will be communicated to the advisory board on a regular basis to keep its members informed of progress.
- Quality Assurance. Describe any evaluation processes and activities that will be utilized to determine the effectiveness of the QI plan's implementation, including measures and outcomes.

After awards are made, CMS will work with the bridge organization to develop a QI Plan that will be updated and reviewed annual. CMS will also provide bridge organizations with quality improvement resources and improvement strategies to facilitate sustainable change.

- *Monitoring and Evaluating Potential Duplicative Payments*. Bridge organizations must annually submit a review of potentially duplicative services and a plan to prevent overlap with such services already provided to all community-dwelling beneficiaries in their communities.

Evaluation Strategy

The alignment and coordination of community resources is likely to impact services for the entire community, including community-dwelling beneficiaries assigned to the non-enrolled group. Therefore, the community-level component of Track 3 – Alignment does not lend itself to a randomized evaluation design. To discern the impact of the community level intervention on participant communities, the evaluation strategy will be twofold: (1) a comparison community will be identified that has similar key characteristics (e.g., community size and composition, baseline utilization, and health status) to the intervention community; and (2) comparison community-dwelling beneficiaries from the Track 1 – Awareness Intervention who had identified social needs and were randomized to the Track 1 – Awareness control group will be used to develop a matched comparison group at the beneficiary level for Track 3 – Alignment. This beneficiary-level match will supplement the community-level comparison group. Just as in the other two tracks, the bridge organization is required to screen all community-dwelling beneficiaries who seek health care at participating clinical delivery sites.

The bridge organization must provide CMS and its contractors with the results from the screening tool, including beneficiary identifiers, the social needs identified, and whether community-dwelling beneficiaries identified as having a health-related social need accepted the intervention. The bridge organization must also provide CMS and its contractors with outcome and process data related to community navigation services as detailed in Section 2.4.1.3, Subsection on Collect Data and Document Each Navigation Encounter. The bridge organization's proposal should clearly address the intended engagement of applicable state Medicaid agency/ies, and the ability and willingness of those agencies to submit Medicaid utilization data on ED visits and inpatient admissions to CMS in the event that the usual claims processing data is not timely enough for purposes of this model. The bridge organization must also propose a plan to provide, or have the other participants in their consortium provide, CMS with identifiable, beneficiary-level utilization information for participating community-dwelling

Medicaid beneficiaries in the absence of CMS being able to obtain timely Medicaid claims data from the state Medicaid agency. Baseline information on health-related social needs provided by the bridge organization from the initial screening will be used to appropriately match community-dwelling beneficiaries as comparators. The bridge organization is also required to be responsive to CMS and its contractors regarding requests for site visits and other information.

Milestones

CMS will monitor the performance of each award recipient based on milestones established by this funding opportunity, Terms and Conditions of Award, and the implementation plan approved by CMS. Only those bridge organizations achieving pre-determined milestones will be recommended for a non-competing continuation award for subsequent budget periods.

Applicants will be expected to propose in their implementation plans quality improvement, process measures that assess the activities carried out by the bridge organization and outcome measures that assess the impact of those activities. These measures will be reviewed and approved by CMS after awards are made and will become part of the metrics used to evaluate an award recipient's continued progress. See Table 5 for Track 3 – Alignment milestones and deliverables.

Table 5. Track 3 – Alignment Milestones and Deliverables

Milestones	Deliverable
Start-up by month 12	
Update implementation plan and SOPs detailing communication strategy with clinical delivery sites, screening and referral process, and data sharing and outcome reporting with CMS/contractors	Implementation Plan
Finalize screening tool	Screening tool
Complete Community Resource Inventory	Community Resource Inventory
Train staff in conducting screening or instructions have been developed for self-screening	Implementation Plan
Tailored community referral summary is deployed to participating sites	Implementation Plan
Complete AHC navigator training	Training curriculum for AHC navigators
Deploy AHC navigators to participating sites	Implementation plan
Completion of contracts, MOUs and/ or MOU equivalents with model participants establishing the consortium	Documentation of consortium arrangement between bridge organization and other model participants
Establish formal relationships with clinical delivery sites	Contract, MOU or MOU equivalent with each clinical delivery site
Year 1*	
Submit progress reports on milestones	Report submission after the completion of each quarter

Milestones	Deliverable
Submit first gap analysis report	Gap analysis report
Develop QI plan	QI plan
Submit update to Implementation plan and assessment for program duplication	Implementation Plan
Year 2	
Screen 75,000 community-dwelling beneficiaries * Screening figures were calculated from the figures needed for treatment and then assuming a 40% participation rate in navigation services, 75% consent rate and 13% high risk rate among community-dwelling beneficiaries.	Data submission to CMS or its contractors
Provide navigation services to 2,925 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submission after the completion of the second and fourth quarters
Submit data on health-related social needs screening	Data submission to CMS or its contractors
Provide refresher training for AHC navigators	Report submission after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health –related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit Medicaid utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups (at the discretion of CMS)	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submission after the completion of each quarter
Submit second gap analysis	Gap analysis report
Submit first QI plan progress report	QI plan
Submit update to Implementation plan and assessment for program duplication	Implementation Plan
Year 3	
Screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide navigation services to 2,925 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submitted after the completion

Milestones	Deliverable
	of the second and fourth quarters
Submit data on health-related social needs screenings	Data submission to CMS or its contractors
Complete refresher training for AHC navigators	Report submitted after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health-related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit Medicaid utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups (at the discretion of CMS)	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submitted after the completion of each quarter
Submit third gap analysis report	Gap analysis report
Submit second QI plan progress report	QI plan report
Submit update to Implementation plan and assessment for program duplication	Implementation Plan
Year 4	
Screen 75,000 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide navigation services to 2,925 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submitted after the completion of the second and fourth quarters
Submit data on health-related social needs screenings	Data submission to CMS or its contractors
Complete refresher training for AHC navigators	Report submitted after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health-related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have state Medicaid agency submit Medicaid utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups (at the discretion of CMS).	Data submission to CMS or its contractors
Submit progress reports on milestones	Reports submitted after the

Milestones	Deliverable
	completion of each quarter
Submit fourth gap analysis report	Gap analysis report
Submit third QI plan progress report	QI plan report
Submit update to Implementation plan and assessment for program duplication	Implementation Plan
Year 5	
Screen 37,500 community-dwelling beneficiaries	Data submission to CMS or its contractors
Provide navigation services to 1,463 community-dwelling beneficiaries	Data submission to CMS or its contractors
Update the Community Resource Inventory	Report submitted after the completion of the second and fourth quarters
Submit data on health-related social needs screenings	Data submission to CMS or its contractors
Complete refresher training for AHC navigators	Report submitted after the completion of each quarter
Submit outcomes (referrals made, referrals completed, and status of health-related social needs at close-out) for the intervention group	Data submission to CMS or its contractors
Submit Medicare and Medicaid identification numbers	Data submission to CMS or its contractors
Submit or have the state Medicaid agency submit Medicaid utilization and payment data for community-dwelling Medicaid beneficiaries in the intervention and control groups (At the discretion of CMS).	Data submission to CMS or its contractors
Submit progress reports on milestones	Report submitted after the completion of each quarter
Submit final gap analysis report	Gap analysis report
Submit final QI plan progress report	QI plan
Submit update to Implementation plan and assessment for program duplication	Implementation Plan

2.5 Technical Assistance and Information for Potential Applicants

Prior to the application deadline, CMS will host a series of Open Door Forums (e.g., webinars) to provide details about this model and to answer questions from potential applicants. Information about the forums will be posted on the Innovation Center website at https://innovation.cms.gov.

CMS expects to award two support contracts: one for evaluation and one for program implementation. The evaluation contractor will collect and analyze data necessary to evaluate each track. The overarching goal of the evaluation is to determine if the interventions across each

of the three tracks (1) produces savings to Medicare and Medicaid and (2) improves health outcomes of community-dwelling beneficiaries. Insomuch as we are able and powered to do so, CMS will identify factors that are driving the identified impact and any savings and use qualitative data to inform our quantitative findings.

The implementation contractor will support program operations including: convening a TEP to develop a tool for assessing health-related social needs; developing a system for assigning community-dwelling beneficiaries to the intervention group; providing technical assistance; creating and facilitating a learning system; assisting in the monitoring of program implementation, including data exchange and potential for payment duplication; and supporting programmatic operations.

The implementation or evaluation contractors will assist in conducting site visits and interviews to observe program implementation, facilitating continuous quality improvement, and evaluating the qualitative impacts of the program. CMS may request modification to implementation plans and associated documents (e.g., HRES, assessments of program duplication and SOPs) to facilitate the concatenation of program operations with contractor functions. CMS will provide details to award recipients for contractor related work after awards are made.

3. Award Information

3.1 Total Funding

The total amount of federal funds available is anticipated to be up to:

- $12 million to 12 bridge organizations to implement Track 1 – Awareness intervention,
- $30.84 million to 12 bridge organizations to implement Track 2 – Assistance intervention, and
- $90.20 million to 20 bridge organizations to implement Track 3 – Alignment intervention.

3.2 Award Amount

CMS expects to award up to 44 cooperative agreements ranging between $1 million and $4.51 million each to cover the five-year period of performance. Please refer to Section 1 Executive Summary for the approximate award amount for each AHC intervention track. Cooperative agreements will be awarded with consideration to: (1) demonstrated commitment to coordinate and collaborate with model participants including the state Medicaid agency/ies, (2) overall cost effectiveness of Track implementation proposal, (3) overall quality of the proposal and the ability to meet project goals, and (4) availability of funding. The amount of funding for each cooperative agreement award made to award recipients will depend on variables detailed in the criteria below (see Section 6.1 Application Review Information - Criteria).

3.3 Anticipated Award Dates

Please refer to Section 1 Executive Summary for the anticipated award date.

3.4 The Period of Performance

The budget and project period for each cooperative agreement awarded will be five years from the date of award. The estimated project period is January 01, 2017 – December 31, 2021. The grant period consists of five 1-year budget periods. Please refer to Section 1 Executive Summary for periods of performance and budget.

Year one 12-month project and budget period: January 01, 2017 to December 31, 2017.

Year two 12-month project and budget period: January 01, 2018 to December 31, 2018.

Year three 12-month project and budget period: January 01, 2019 to December 31, 2019.

Year four 12-month project and budget period: January 01, 2020 to December 31, 2020.

Year five 12-month project and budget period: January 01, 2021 to December 31, 2021.

3.5 Number of Awards

Please refer to Section 1 Executive Summary for the number of awards.

3.6 Type of Award

These awards will be structured as cooperative agreements. The Federal Grant and Cooperative Agreement Act of 1977, 31 U.S.C. 6301, defines the cooperative agreement as an alternative assistance instrument to be used in lieu of a grant whenever substantial Federal involvement with the award recipient during performance is anticipated. Therefore, statutes, regulations, policies, and the information contained in the HHS Grants Policy Statement that are applicable to grants also apply to cooperative agreements, unless the award itself states otherwise.

CMS may request an amendment of the applicant's proposals following award selection, including for the purposes of incorporating best practices around the coordination of clinical and community services and resources. CMS will monitor and evaluate award recipients' activities performed under the cooperative agreement, including monitoring, measuring and evaluating achievement of AHC goals. CMS anticipates informal weekly communication with bridge organizations.

Continued disbursement of AHC funding over the performance period of the award is conditional on the bridge organization meeting specified progress milestones and the availability of funds. These milestones will be further detailed in the terms and conditions of the cooperative agreement.

4. Eligibility Information

4.1 Eligible Applicants

CMS invites community-based organizations, individual and group healthcare practices, hospitals and health systems, institutions of higher education (IHE), local government entities, tribal organizations and for-profit and not-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers to apply. Applicants from all 50 states, United States territories (American Samoa,

Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands), and the District of Columbia may apply to become bridge organizations. Eligible IHEs are limited to college and university health care affiliates delivering clinical services, such as community-based clinics, hospital networks, and health systems. Local government entities include, but are not limited to, local units of state and regional agencies where such classifications exist, local and tribal health departments, local public housing authorities, Indian housing authorities, and local community service agencies. Local government entities *exclude* state Medicaid agencies.

4.1.1 Cost Sharing or Matching Requirements

Cost sharing or matching is not permitted.

4.1.2 Foreign and International Organizations

Foreign and international organizations are not eligible to apply.

4.1.3 Faith-Based Organizations

Faith–based organizations are eligible to apply.

4.1.4 Community-Based Organizations

Community-based organizations are eligible to apply.

4.1.5 Tribal Organizations

American Indian and Alaskan Native Tribal Organizations are eligible to apply.

4.2 Ineligibility Criteria

- CMS funds will not pay directly or indirectly for the provision of community services (e.g., housing, food, violence intervention programs, and transportation) in any of the three tracks. Rather, award money will fund systems change interventions to connect community-dwelling beneficiaries with community services.
- State Medicaid agencies are ineligible to apply as lead applicants or bridge organizations.
- Only one award recipient will be funded for a given geographic target area, regardless of whether applications are received for more than one track in the same or an overlapping geographic target area. Notwithstanding the requirement of geographic exclusivity, CMS may choose to award more than one cooperative agreement in a single state.
- An applicant can only be funded to implement one AHC track.
- Funds shall not be used to build or purchase health information technology that exceeds more than 15 percent of the total costs of the applicant's proposed budget.
- Medicare Advantage plans and Program of All-Inclusive Care for the Elderly (PACE) organizations are ineligible to apply because funding these organizations to address the social needs of a population that is broader than the population for which they were created may alter the fundamental and operational nature of these organizations to the detriment of their respective programs. Clinical providers and practices that accept Medicare Advantage and PACE providers may be clinical delivery sites.

- CMS will not review applications that merely restate the text within the FOA. Applicants should detail their approach to achieving program goals, milestones, and benchmarks. Reviewers will note evidence of how effectively the applicant includes these elements in their application.
- CMS will not fund proposals that do not submit a contract, MOU or MOU equivalent from the appropriate number of state Medicaid agencies needed to meet the model requirements outlined in this funding announcement demonstrating its (their) commitment to consortium participation.
- CMS may deny selection to an otherwise qualified applicant on the basis of information found during a program integrity review regarding the bridge organization, its participants or any other relevant individuals or entities.

4.3 Threshold Criteria

- Application deadline: Applications not received electronically through www.grants.gov by the application deadline March 31, 2016 will not be reviewed.
- Applications will be considered for funding only if the application meets the requirements as outlined in Section 4 Eligibility Information.
- Letter of Intent (LOI): To submit your LOI, applicants are required to use the online LOI submission form located at: http://innovationgov.force.com/ahc by February 8, 2016.
- Page limits for Track 1 – Awareness: The application project narrative shall not be more than 35 pages in length. Applications that exceed the 35-page limit will not be reviewed. Documentation from state Medicaid agencies and other model participants is not included in this page limit. The Implementation Plan and Assessment of Program Duplication are not included in this page limit. Standard forms are not included in this page limit.
- Page limits for Track 2 – Assistance: The application project narrative shall not be more than 45 pages in length. Applications that exceed the 45-page limit will not be reviewed. Documentation from state Medicaid agencies and other model participants is not included in this page limit. The Implementation Plan and Assessment of Program Duplication are not included in this page limit. Standard forms are not included in this page limit.
- Page limits for Track 3 – Alignment: The application project narrative shall not be more than 60 pages in length. Applications that exceed the 60-page limit will not be reviewed. Documentation from state Medicaid agencies and other model participants is not included in this page limit. The Implementation Plan and Assessment of Program Duplication are not included in this page limit. Standard forms are not included in this page limit.
- Applicants may apply to no more than two AHC tracks; however, applicants must complete a separate proposal for each track. Applicants submitting more than two proposals will not be reviewed for any track. Please note that duplicate applications do not count as a submission.
- Page limits for Budget Narratives: The budget narrative shall not be more than 15 pages in length. Budget narratives that exceed the 15-page limit will not be reviewed.
- Applicants must include with their application a contract, MOU or MOU equivalent with the appropriate number of state Medicaid agencies that cover community-dwelling

beneficiaries who the Applicant believes will seek care at a participating clinical delivery site and be offered an AHC intervention. See Section 5.2 Application Structure and Content, Subsection on Contract, MOU or MOU Equivalent with State Medicaid Agency for additional information.

- Applicants must include one or more contracts, MOUs or MOU equivalents that in total covers each of the three minimum types of clinical delivery sites that the Applicant expects to participate in the AHC model (that is, a contract, MOU or MOU equivalent from a (1) hospital, (2) behavioral health provider, and (3) healthcare provider or practice that furnishes primary care health services.) See Section 5.2 Application Structure and Content, Subsection on Contracts, MOUs or MOU Equivalents with Clinical Delivery Sites for additional information.
- Applicants must identify the AHC Track (i.e., Track 1 – Awareness, Track 2 – Assistance, or Track 3 – Alignment) to which they are applying in Item 15 on the SF 424 Application for Federal Assistance.
- Applicants are strongly encouraged to use the review criteria information provided in Section 5 Application Information, Section 6 Application Review Information and Appendix 2: Application and Submission Information, to ensure that the application proposal adequately addresses all criteria.

5. Application Information

5.1 Application Package

Application materials will be available at http://www.grants.gov. Please note that CMS requires applications for all announcements to be submitted electronically through the Grants.gov website. Applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website. Refer to Appendix 2: Application and Submission Information for specific instructions.

Application Format

Applications determined to be ineligible, incomplete, and/or nonresponsive based on the initial screening may be eliminated from further review. However, the CMS/OAGM/GMO, in its sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

- The following page size must be used: 8.5” x 11” letter-size pages (one side only) with 1” margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5” x 11”.
- All pages of the project and budget narratives must be paginated in a single sequence.
- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced.

- The Budget Narrative must be single-spaced.
- Tables included within any portion of the application must have a font size of at least 12-point with a 14 CPI and may be single spaced. Tables are counted towards the applicable page limits mentioned in Section 4. Eligibility Information of this funding opportunity announcement.
- The project abstract is restricted to a one-page summary which may be single-spaced.
- The following required application documents are excluded from the page limitations described in Section 4. Eligibility Information of this funding opportunity announcement: Standard Forms, applicant's copy of its Letter of Intent for the AHC model (if previously submitted) and the Project Abstract.

The application is expected to address how the applicant will carry out the implementation and planning work required to meet AHC goals. The application must address application components for the intervention track the applicant is proposing to implement.

Application Package

The application components listed in the following tables are required and must be submitted with the application. Failure to submit these forms will result in an ineligible application that will not be reviewed.

Table 6. Standard Forms: Track-specific Application Requirements (Standard Format)

Application Component	Max Pages	Points
Standard Format		
A. Project Abstract		
Track 1	1	0
Track 2	1	0
Track 3	1	0
B. SF 424		
Track 1	No page limit	0
Track 2	No page limit	0
Track 3	No page limit	0
C. SF 424A		
Track 1	No page limit	0
Track 2	No page limit	0
Track 3	No page limit	0
D. SF 424B		
Track 1	No page limit	0
Track 2	No page limit	0
Track 3	No page limit	0

Application Component	Max Pages	Points
E. SF LLL		
Track 1	No page limit	0
Track 2	No page limit	0
Track 3	No page limit	0
F. Project Site Location Form		
Track 1	No page limit	0
Track 2	No page limit	0
Track 3	No page limit	0

Table 7. Track-specific Application Requirements – Project Narrative Page and Point Totals

Application Component	Max Pages	Points
Project Narrative Totals		
Track 1	35	85
Track 2	45	110
Track 3	60	145

Table 8. Track-specific Application Requirements – Project Narrative

Application Component	Track 1 Points	Track 2 Points	Track 3 Points
Project Narrative			
A. Intervention Design –Core Elements			
1. Background	5	5	5
2. Geographic Target Area	10	10	10
3. Systematic Screenings for health-related social need	10	10	10
4. Risk Stratification	N/A	5	5
5. Community Resource Inventory	10	10	15
6. Tailored Community Referral Summary	10	10	10
7. Navigation Services	N/A	10	10
B. Bridge Organizations			
1. Background	10	10	10
C. Stakeholder Engagement			
1. State Medicaid Agency	10	10	10

Application Component	Track 1 Points	Track 2 Points	Track 3 Points
2. Consortium	10	10	10
3. Clinical Delivery Sites	10	10	10
4. Community Service Providers	N/A	10	10
D. Community Integrator (Track 3 only)			
1. Advisory Board	N/A	N/A	10
2. Data Sharing	N/A	N/A	10
3. Gap Analysis	N/A	N/A	5
4. Quality Improvement Plan	N/A	N/A	5

Table 9. Track-specific Application Requirements – Implementation Plan Page Totals

Application Component	Max Pages
Implementation Plan Components	
Track 1	10
Track 2	12
Track 3	15
Contract(s),MOU(s) or MOU equivalent(s) with Clinical Delivery Sites	
Track 1	Unlimited
Track 2	Unlimited
Track 3	Unlimited
Contract(s), MOU(s) or MOU equivalent(s) with Community Service Providers	
Track 1	Unlimited
Track 2	Unlimited
Track 3	Unlimited
Health Resource Equity Statement	3

Table 10. Track-specific Application Requirements – Implementation Plan

Application Component	Track 1 Points	Track 2 Points	Track 3 Points
A. Implementation Plan	8	8	8
B. Contract(s), MOU(s) or MOU equivalent(s) with State Medicaid Agency	25	25	25

Application Component	Track 1 Points	Track 2 Points	Track 3 Points
C. Contract(s), MOU(s) or MOU equivalent(s) with Clinical Delivery Sites			
1. Hospitals	5	5	5
2. Primary Care Provider	5	5	5
3. Behavioral Health Service Providers	5	5	5
D. Contract(s), MOU(s) or MOU equivalent(s) with Community Service Providers	0	0	10
E. Health Resource Equity Statement	2	2	2

Table 11. Track-specific Application Requirements – Assessment of Program Duplication and Plan for Avoiding Duplication

Application Component	Max Pages	Points
Assessment of Program Duplication		
Track 1	2 pages per checklist / No max number of checklists	0
Track 2	2 pages per checklist / No max number of checklists	0
Track 3	2 pages per checklist / No max number of checklists	0

Table 12. Track-specific Application Requirements – Budget Narrative Pages and Points Total

Application Component	Max Pages	Points
Budget Narrative		
Track 1	15	15
Track 2	15	15
Track 3	15	15

Table 13. Track-specific Application Requirements – Summary of Total Available Application Points

Application Component	Track 1	Track 2	Track 3	Component Total

Application Component	Track 1	Track 2	Track 3	Component Total
Project Narrative	85	110	145	**340**
Implementation Plan	50	50	60	**160**
Assessment of Program Duplication	0	0	0	**0**
Budget Narrative	15	15	15	**45**
Total Available Points	**150**	**175**	**220**	**545**

5.2 Application Structure and Content

Standard Mandatory Forms

The following standard forms are found in the Grants Application Package at the Grants.gov website and must be completed with an electronic signature and submitted as part of the proposal:

- Project abstract summary

  A one-page abstract should serve as a succinct description of the proposed project and should include the track the applicant is applying for, the goals of the project, the total budget, the number of projected clinician participants, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference to other parts of the application. Personal identifying information should be excluded from the abstract. In the Grants Application Package that can be found at www.grants.gov, select the Project Abstract Summary and complete the form.

- SF-424: Official Application for Federal Assistance

  Note: On SF 424 "Application for Federal Assistance":

  - On Item 15 "Descriptive Title of Applicant's Project", state the specific cooperative agreement opportunity for which you are applying: [Accountable Health Communities]. Include the specific AHC intervention track for which the application is being submitted.
  - Check "No" to item 19c, as Review by State Executive Order 12372 does not apply to this cooperative agreement funding opportunity.

- SF-424A: Budget Information Non-Construction
- SF-424B: Assurances-Non-Construction Programs
- SF-LLL: Disclosure of Lobbying Activities.

  All applicants must submit this document. If your entity does not engage in lobbying, please insert "Non-Applicable" on the document and include the required Authorized Organizational Representative (AOR) name, contact information, and signature. Please note that the application kit available online on the Grants.gov website is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. This form is required as part of your application package and must be submitted for your application to be considered eligible for review.

- Project Site Location Form(s)

  All applicants must submit this form. Please note that the application kit available online in Grants.gov is utilized for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. This form is required as part of your application package and must be submitted for your application to be considered eligible for review.

Project Narrative

The project narrative is expected to address how the applicant will carry out the design and implementation work required to meet the AHC program goals. Refer to Section 4.3 Threshold Criteria for project narrative page limits by track. All sections of the project narrative must be clearly labeled with the title of the section or subsection, in accordance with the headers outlined in the chart below. The applicant must produce a detailed and fully developed proposal describing its ability to meet the program requirements and to engage the stakeholders necessary

to link clinical and community services and successfully implement the proposed AHC intervention.

The Project Narrative Attachment Form can be found in the Grants Application Package at www.grants.gov; select the Project Narrative Attachment Form and "Add Mandatory Project Narrative File."

Intervention Design

The Intervention Design section shall provide a detailed and fully developed proposal for implementing the core elements of the selected AHC intervention.

A. Core Elements

Core elements of the Track 1 – Awareness Intervention include: (1) systematic health-related social needs screenings for certain beneficiaries, (2) identification of community-dwelling beneficiaries with 2 or more ED visits, (3) random assignment of community-dwelling beneficiaries with 2 or more ED visits and those with less than 2 ED visits to intervention and control groups, (4) provision of usual care to all community-dwelling beneficiaries assigned to control group, and (5) usual care, along with an offer of a review and distribution of a tailored community referral summary for all community-dwelling beneficiaries assigned to intervention group.

Core elements of the Track 2 – Assistance Intervention include: (1) the first through third core elements from track 1, (2) risk stratification of community-dwelling beneficiaries based on number of ED visits, (3) random assignment to intervention and control groups for all community-dwelling beneficiaries with 2 or more ED visits, (4) offer of a review and distribution of tailored community referral summary for all community-dwelling beneficiaries with unmet health-related social needs who are not assigned to intervention group (along with usual care), and (5) offer of a review and distribution of tailored community referral summary and navigation services for all high-risk community-dwelling beneficiaries with unmet health-related social needs who are assigned to intervention group (along with usual care).

Core elements of the Track 3 – Alignment Intervention include: (1) the first through fifth core elements in track two, and (2) continuous quality improvement and gap analysis for community and clinical resource alignment.

See Section 2.4.1.2 Track 1 – Awareness Intervention Proposal Requirements, Section 2.4.1.3 Track 2 – Assistance Intervention Proposal Requirements, and Section 2.4.1.4 Track 3 – Alignment Intervention Proposal Requirements for track-specific proposal requirements and additional information related to each project narrative subheading.

1. Background

   The applicant shall describe its interest in and need for the proposed AHC intervention track. The proposal shall also describe any current work related to interdisciplinary collaboration between clinical and health-related community service providers and how an award through this cooperative agreement would build upon these collaborations.

2. Geographic Target Area and Percent Capture of Community-Dwelling Beneficiaries

   Applicants must clearly describe in their applications the geographic target area in which a Medicare and/or Medicaid beneficiary must live in order to be a community-dwelling beneficiary for purposes of the model. Descriptions could include zip codes, cities/counties, or any other unit that will make clear the specific boundaries of the geographic target area. Applicants delivering the AHC intervention to rural populations must address strategies for intervention fidelity (ensuring that the intervention is delivered as designed) in these communities. In addition, applicants must describe the limitations of their referral and navigation networks.

   Applicants should review the track specific milestones related to screening, randomization, and navigation (see Table 3 – Track 1 Deliverables and Milestones, Table 4 – Track 2 Deliverables and Milestones, and Table 5 – Track 3 Deliverables and Milestones) and demonstrate their capacity to achieve milestones.

   Applicants should describe the: (1) health-related social needs of the proposed geographic target area and how those needs were identified as well as the applicant's logic for addressing those needs through the AHC intervention; (2) community resources and the current capacity of those resources to meet the needs of the community; (3) supplemental health-related social need domains anticipated to be addressed through the intervention along with the applicant's logic for address those needs; and (4) currently available community needs assessments and community action groups addressing health-related social needs.

   In order for an area to qualify as a geographic target area for Track 3 – Alignment, participating clinical delivery sites (or those that the applicant anticipates will participate) must have collectively provided health care services to at least 51 percent of the total population of community-dwelling beneficiaries who live in the geographic target area in the 12-month period prior to the date the application is submitted (or be able to adequately document that they will be able to screen this population during the performance period). In addition, Track 3 – Alignment applicants should describe the commitment or intended commitment of the applicable Medicaid agency/ies to participate in the model, as well as the commitment or the intended means of gaining commitments from local payers (e.g., Medicare Advantage plans and Medicaid managed care organizations, local government [e.g., local health department, housing authority], and other community participants [e.g., local non-profit organizations, Area Agency on Aging and Centers for Independent Living]) who support the implementation of the AHC intervention and are committed to the goals of AHC.

3. Systematic Screenings for Health-Related Social Needs

   The applicant shall describe its plan to screen all community-dwelling beneficiaries accessing health care at participating clinical delivery sites. The applicant should consider local policy, communication strategies between the bridge organization and clinical delivery sites, frequency of screenings and necessary protocols, randomization methodology, and community navigation tracking (Tracks 2 & 3 only). The applicant should also consider the process for the reporting of data from the

screening tool to CMS and how the delivery of a systematic screening impacts the patient flow at clinical delivery sites. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Screening Tool for additional details.

4. Risk Stratification

   The applicant shall describe its plan to incorporate the screening and referral process into their participating clinical delivery sites' patient flow. The applicant should include a description of the infrastructure in place to record patient information obtained during the screening process, report screening data on each community-dwelling beneficiary in real time, and discuss logistical challenges and mitigation strategies necessary for intervention status determination based on risk self-reporting through the screening tool. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Risk Stratification and Randomization for additional details.

5. Community Resource Inventory

   The applicant must describe the community resource inventories available within their community. The applicant must describe how these inventories will be leveraged to create a comprehensive inventory that addresses core health-related social need domains and selected supplemental health-related social need domains. If creating a new inventory, then the applicant shall justify the creation of this new inventory for the AHC intervention. The applicant shall also address the frequency for updating this inventory (no less than once every six months). See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Community Resource Inventory for additional details.

6. Tailored Community Referral Summary

   The proposal shall describe the content of the tailored community referral summary and the process for distributing this referral summary to community-dwelling beneficiaries assigned to receive it. The proposal should also include information on how the bridge organization will maintain a record of when community-dwelling beneficiaries receive the summary as well as the information contained in the summary. The applicant must detail how the referral summary will be tailored to only provide referrals to community services that address the health-related social needs of each community-dwelling beneficiary that are identified through the health-related social needs screening. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Tailored Community Referral Summary for additional details.

   Track 1 – Awareness applicants shall address their process to ensure that only community-dwelling beneficiaries assigned to the intervention group receive the community referral intervention.

7. Navigation Services (Track 2 and 3 only)

   The AHC navigator has four primary responsibilities: (1) personal interview, (2) development of action plan, (3) follow-up, and (4) documentation and data collection. The applicant shall describe how the AHC navigator(s) will provide navigation

services to high-risk community-dwelling beneficiaries. The applicant must describe the process for training AHC navigators and collecting data on the navigation services being conducted. The applicant shall describe the tools (and provide citations of the tool's validity, as applicable) that will be used for accomplishing the four AHC navigator responsibilities. The applicant shall indicate how primary AHC navigator responsibilities will be monitored and policies for ensuring consistent navigation services across clinical delivery sites. See Section 2.4.1.1 – Model Test Proposal Requirements – All Tracks for additional information.

B. Bridge Organization – Background

The bridge organization has seven or eight core responsibilities, depending on the track: (1) clinical and community relationship development and maintenance; (2) development and piloting of standardized health-related social needs screening from CMS question bank; (3) community resource inventory development and maintenance; (4) monitoring of the intervention at clinical delivery sites; (5) program and financial management as required by the cooperative agreement; (6) data collection and submission for CMS monitoring and evaluation; (7) coordination with No Wrong Door/ Aging and Disability Resource Center (ADRC) programs, Medicaid health homes, managed care organizations, State Innovation Model grants and/or other federal and state programs with potential for overlap, including plans to avoid potential overlap; and (8) [Track 3 only] gap analysis, quality improvement planning and coordination of advisory board to improve delivery and availability of community services to meet identified needs. The applicant shall describe its experience with and capacity to carry out these core responsibilities and how the applicant will manage relationships with the state Medicaid agency and other model participants. See Section 2.4.1.1 – Model Test Proposal Requirements – All Tracks for additional information.

C. Stakeholder Engagement

The stakeholder engagement section of the project narrative shall delineate the capacity of key stakeholders (state Medicaid agency(ies), clinical delivery sites, and community service providers) to incorporate their responsibilities under the model into their workflow. The applicant shall also describe how it will manage the administrative functions necessary to coordinate stakeholders and meet cooperative agreement requirements. The applicant must also describe the experience of its model participants (or intended participants) in using data to drive quality improvement efforts.

1. State Medicaid Agency

   State Medicaid agencies that agree to participate in the model will have three core responsibilities: (1) providing required information on utilization outcomes for model participants covered under Medicaid from data submitted by providers to the state Medicaid agency to CMS via the typical Medicaid claims processes or, when those processes do not provide timely enough data, through direct submission of such data to CMS or its contractors; (2) collaborating with the bridge organization on sustainability and scalability planning; and (3) dedicating staff time for AHC related activities. The applicant shall describe its intended relationship with the state Medicaid agency (contract, MOU or MOU equivalent), and the agency's intended role and responsibility in the implementation of the AHC intervention. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on State

Medicaid Agency for additional details and the Subsection on Contract, MOU or MOU Equivalent with State Medicaid Agency for contract, MOU or MOU equivalent requirements.

2. Consortium

   The applicant must include a brief statement (no more than one page) attesting that the applicant and each consortium participant (or potential participant) that are known at the time of the application are eligible entities to participate in this cooperative agreement and do not have a conflict of interest. Through this statement the applicant must describe its plan to establish the consortium within 12 months of the receipt of award notice, including but not limited to, desired consortium participants, flow of funding and data, timeline for establishment of consortium, and parameters of the relationships (i.e., roles and responsibilities). CMS expects that a contract, MOU or MOU equivalent will accompany the application and further detail this relationship for each consortium participant. At minimum the consortium must include the state Medicaid agency that would be expected to pay for Medicaid-covered services furnished to its community-dwelling Medicaid beneficiaries at the applicant's participating clinical delivery sites. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on State Medicaid Agency for additional details.

3. Clinical Delivery Sites

   Each bridge organization must, for purposes of the AHC model, establish a relationship with a minimum number of clinical delivery sites including at least one of each of the following three types of clinical delivery sites: (1) a hospital, (2) a healthcare provider or practice that furnishes primary care services, and (3) a behavioral health service provider. The applicant shall discuss its intended relationship with clinical delivery sites, the clinical delivery sites' roles and responsibilities in implementing the AHC intervention, and the clinical delivery sites' experience integrating process changes, such as screenings and referrals, into the clinical setting. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Clinical Delivery Sites for additional details and Section 5.2 Application Structure and Content, Subsection on Contracts, MOUs or MOU Equivalent with Clinical Delivery Sites for requirements for contracts, MOUs and MOU equivalents.

4. Community Service Providers (Tracks 2 and 3)

   Community service providers have four primary responsibilities: (1) supporting the bridge organization in the planning process and development of the community resource inventory; (2) supporting bridge organization/AHC navigator to track AHC participants utilizing community service provider resources and related outcomes (Tracks 2 – Assistance and 3 – Alignment); (3) participating in the advisory board (Track 3 – Alignment); and (4) informing the Gap Analysis and QI efforts (Track 3 – Alignment). The applicant shall describe its relationship (or intended relationship) with community service providers and its assessment of their ability to fulfill these functions under the model. See Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Community Service Providers for additional details and

Section 5.2 Application Structure and Content, Subsection on Contracts, MOUs or MOU Equivalents with Community Service Providers for contract, MOU or MOU equivalent requirements.

D. Integrator Role (Track 3 only)

The applicant must describe its plan for fostering community-wide realignment of resources to more effectively address health-related social needs for the target community-dwelling beneficiaries. This description shall include how the bridge organization will facilitate data sharing, accept input from the advisory board for gap analysis preparation, and inform community level decision-making. The proposal shall present a plan for structured data capture and data sharing among the advisory board, the clinical delivery sites, and the community service providers. The applicant shall describe current efforts and plans (supported by the cooperative agreement) to assess community health-related needs, identify areas for improvement and implement strategies for addressing identified needs.

1. Advisory Board (Track 3 only)

   Applicants must establish an advisory board that includes the state Medicaid agency(ies), local government, all participating clinical delivery sites, health-related community service providers, local health and community service payers and providers, and community-dwelling beneficiaries and their caregivers. The proposal should list potential advisory board members and include a contract, MOU or MOU equivalent for each participating person or entity. The proposal shall also include an overview of the advisory board's potential operating procedures and at a minimum describe frequency of meetings, structure and decision making process, and role of the advisory board in intervention management.

2. Data Sharing

   Applicants to all tracks shall include a statement of status, developed by participating state Medicaid agency(ies), towards meeting ongoing Transformed – Medicaid Statistical Information System (T-MSIS) milestones including continued progress towards current and future goals as well as a supplemental statement outlining a plan for coordinating with CMS to provide required AHC data in the absence of timely T-MSIS data. Each applicant must also outline state and local laws that apply to data sharing between clinical and community service providers.

   Applicants in Track 3 – Alignment must describe plans for tracking and reporting on each beneficiary's service use and costs across all care settings pertinent to the AHC model, including community services. Alternatively, applicants may demonstrate access to existing IT infrastructure that facilitates the bidirectional exchange of clinical and community service data and submit a plan (including costs) to utilize (or adapt as appropriate) the existing IT infrastructure.

3. Gap Analysis (Track 3 only)

   The proposal shall describe the applicant's ability to conduct a gap analysis. It should specifically address currently available local data and assessments related to clinical health and health-related social needs and planned information sources and activities to assess the geographic target area's capacity to meet community needs. The

proposal must provide an overview of the applicant's process for conducting a gap analysis and the applicant's experience with similar efforts.

4. Quality Improvement (QI) Plan (Track 3 only)

   The applicant's QI plan must address goals, terminology, management, monitoring, and QI methodology and quality assurance. The proposal must provide a summary for each of the QI elements, including plans for engagement of the advisory board and other model participants. After initial plans for QI included with proposals have been received and awards distributed, CMS and its contractors will work with award recipients to support quality improvement activities including QI plan development.

Implementation Plan

(10 pages for Tracks 1; 12 pages for Track 2; 15 pages for Track 3)

Applicants must submit a detailed implementation plan, with the application, that describes how the applicant intends to implement the track to which it is applying and:

- A detailed work plan that includes milestones, dates and task owners for the start-up period;
- A high-level work plan outlining milestones, dates and task owners for the duration of the period of performance;
- A narrative and diagram of the proposed organizational structure detailing relationships with model participants (i.e., state Medicaid agency, clinical delivery sites, and community service providers) and the flow of funds, data, and communications;
- Process descriptions for staff training and intervention rollout, which the applicant must further develop into standard operating procedures (SOPs) if awarded a cooperative agreement;
- Policies and procedures for screening and referral, community service navigation services, and integrator role functions (for detailed descriptions of each intervention, see Sections 2.4.1.2 Track 1 – Awareness Intervention Proposal Requirements, 2.4.1.3 Track 2 – Assistance Intervention Proposal Requirements, and 2.4.1.4 Track 3 – Alignment Intervention Proposal Requirements);
- An assessment of risks to implementation and assumptions that may impact projected timelines, and mitigation strategies for reducing the probability of the risk occurring;
- The driver diagram, which serves as a framework for intervention design and implementation and establishes self-directed performance indicators for quality improvement;
- Assessments of program duplication; and
- A Health Resource Equity Statement (HRES).

Applicants should submit the Implementation Plan in the Grants Application Package that can be found at www.grants.gov; select the "Other Attachment Form" and "Add Other Attachment." The header of the implementation plan should be clearly labeled as "Implementation Plan."

Contract, MOU or MOU Equivalent with State Medicaid Agency

A contract, MOU or MOU equivalent must be submitted from the state Medicaid agency(ies) (or equivalent organization responsible for operating the Medicaid programs in the geographic region in which the model is to take place) along with the application. Each contract, MOU or MOU equivalent must address each role and responsibility criteria for consortium participation described in Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on State Medicaid Agency.

Applicants should ensure that the following information is included in each contract, MOU or MOU equivalent:

(1) Statement of status towards meeting ongoing T-MSIS milestones including continued progress towards current and future goals;

(2) Summary of local, state and federal laws and policies regulating the release of Medicaid claims data from AHC model participants to CMS and an overview of the process and timeline for obtaining Medicaid claims data;

(3) Supplemental statement outlining a plan for coordinating with CMS to provide required AHC data in the absence of timely T-MSIS data;

(4) Description of understood role and responsibilities for the respective track;

(5) Description of key personnel;

(6) Summary or list of state-run initiatives with the potential for overlap or duplicative services operating in the target area, including brief descriptions of such potentially duplicative services;

(7) Concurrence on Assessment of Program Duplication with respect to services that are paid by the state Medicaid agency;

(8) Verification from state Medicaid agency on clinical delivery sites' estimates (or exact counts) of community-dwelling Medicaid beneficiary ED utilization in the previous 12 months;

(9) Commitment to working with bridge organization to establish a consortium within 12 months of notice of award (if a consortium does not exist at the time the application is submitted); and

(10) The signatures of authorized organizational representatives (AORs) from both the bridge organization and state Medicaid agency.

A contract, MOU or MOU equivalent with the state Medicaid agency must be uploaded in the application; however, award recipients have up to 12 months after award of the cooperative agreement to finalize the formal consortium relationship. If documentation of the consortium relationship with the state Medicaid agency(ies) is not provided within 12 months of award, CMS will restrict all funds to award recipients until such notice of agreement and an electronic copy of executed agreement is provided to CMS. Award recipients who have not established a consortium with the state Medicaid agency(ies) will not be considered for funding beyond the base budget period.

CMS may request modification to the agreement between the bridge organization and the state Medicaid agency during budget negotiations and post-award to ensure CMS's ability to acquire timely Medicaid claims data for the evaluation of the AHC model.

Applicants should submit each contract, MOU or MOU equivalent in the Grants Application Package that can be found at www.grants.gov; select the "Other Attachment Form" and "Add Other Attachment." The header of the state Medicaid agency contract, MOU or MOU equivalent should be clearly labeled as "State Medicaid Contract," "State Medicaid MOU" or "State Medicaid MOU Equivalent," as applicable.

Contracts, MOUs or MOU Equivalents with Other Model Participants

Applicants should submit contracts, MOUs or MOU equivalents with model participants as discussed above in the Grants Application Package that can be found at www.grants.gov; select the "Other Attachment Form" and "Add Other Attachment." The header of each contract, MOU or MOU equivalent should be clearly labeled as "Community Participant Contract," "Community Participant MOU" or "Community Participant MOU Equivalent" as applicable, and the type of model participant (e.g., Clinical Delivery Site – Behavior Health). All community participant contracts, MOUs, or MOU equivalents should be saved as one PDF file. Each contract, MOU or MOU equivalent must be signed by an authorized organizational representative (AOR).

Model participants participating in the consortium may utilize Business Associate Agreements (BAAs) to carry out work for the model post-award, but should review the cooperative agreement terms and conditions and finalized data reporting requirements to ensure that any existing BAA relationships are adequate to cover the breadth of work described, and update such existing BAA as needed; however, CMS must receive notice and electronic copy of such an agreement within 12 months of notice of award. If any necessary BAAs cannot be executed with required model participants within 12 months of award, CMS will partially restrict funds to award recipients until the BAAs with applicable model participants are executed. Bridge organizations that cannot establish and maintain the necessary relationships with model participants, after awards are made, will be re-evaluated during the non-competing continuation process which could result in an official CMS Corrective Action Plan (CAP), reduced funding and/or ultimately suspending or terminating the cooperative agreement award beyond the base budget period.

Contracts, MOUs or MOU Equivalents with Clinical Delivery Sites

Applicants must submit with their applications at least one or more contracts, MOUs or MOU equivalents that, in total, cover each of the following three types of clinical delivery sites: hospital, primary care provider or practice, and behavioral health service provider. Each contract, MOU or MOU equivalent must address each role and responsibility for intervention implementation described in the Section 2.4.1.1 Model Test Proposal Requirements – All Tracks, Subsection on Model Participants, which for clinical delivery sites includes:

(1) The description of the community-dwelling beneficiary population who have received clinical services in the previous 12 months at the clinical delivery site (specifically address the number of each);

(2) Where possible, the number of community-dwelling beneficiaries who utilized the ED two or more times in the previous 12 months;

(3) The NPI, TIN and any other relevant provider identifiers for providers who will participate in the model;

(4) Commitments to have the bridge organization screen (either directly or through arrangements with them or a third party) all community-dwelling beneficiaries seeking health care services at their site. For hospitals this includes, at a minimum, all community-dwelling beneficiaries who seek health care in the ED, labor & delivery, and inpatient psychiatric units;

(5) Commitment to submit required AHC data to the bridge organization and CMS; and

(6) Description of planned protocols for allowing screening of community-dwelling beneficiaries.

Contracts, MOUs or MOU Equivalents with Community Service Providers

A contract, MOU or MOU equivalent from each intended community service provider is required for Track 3 – Alignment advisory board participants and recommended for Track 1 – Awareness and Track 2 – Assistance applicants. Each contract, MOU or MOU equivalent must describe: previous projects with the applicant related to core domains of health-related social needs or other social determinants of health and plans to use data to support AHC interventions and continuous quality improvement. The contract, MOU or MOU equivalent should also describe the method by which the community service provider will collaborate with the bridge organization to implement the intervention and, in Track 3, will work with the bridge organization to address gaps identified in the gap analysis. Each contract, MOU or MOU equivalent must be uploaded in the application.

Each required contract, MOU or MOU equivalent shall be evaluated based on the following criteria:

(1) Demonstrated understanding of the goals of the AHC model design and implementation;

(2) Commitment to participate in planning process and development of referral design;

(3) Commitment to support AHC navigator tracking of beneficiary utilization of community service provider resources and related outcomes;

(4) Commitment to tracking cost of provision of community services and total number of community-dwelling beneficiaries served;

(5) Descriptions of expertise in the areas for which the organization will receive referrals;

(6) Understanding of the population that will be referred; and

(7) Description of relationship and collaboration experience with applicant.

Assessment of Program Duplication

The Applicant must submit, as an appendix to the applicant's implementation plan, an Assessment of Program Duplication for each program identified as potentially duplicative and a plan for addressing potential duplication. Successful award recipients must only provide community navigation services that are non-duplicative. The Assessment of Program Duplication will compare existing programs to the AHC requirements and protocols as outlined

in the FOA and identify overlaps and gaps. The plan must address how the applicant will leverage existing provision of services and how duplication of payment for services will be avoided. Each assessment shall not exceed two pages. (Note: applicants may submit multiple assessments.) Supporting data that verifies this assessment may be submitted and will not be considered in the final page count. All assessments should be included in one document and the document should be signed post-award by all consortium members to indicate that the document has been reviewed and represents a comprehensive review of potentially duplicative programs. See Appendix 7: Assessment of Program Duplication for a template. Failure to include an unsigned preliminary assessment in the application will deem the entire application ineligible for review.

Applicants should submit the assessment in the Grants Application Package that can be found at www.grants.gov; select the "Other Attachment Form" and "Add Other Attachment." The header of the Assessment of Program Duplication should be labeled as "Assessment of Program Duplication."

Health Resource Equity Statement

The applicant must submit a Health Resource Equity Statement (HRES) (also known as a Disparities Impact Statement), as an appendix to the applicant's implementation plan. Applicants should collaborate with their model participants to develop the HRES. The HRES should include: a statement of need, an action plan and a performance assessment and data description. See Appendix 8: Health Resource Equity Statement for a template.

Applicants should submit the HRES in the Grants Application Package that can be found at www.grants.gov; select the "Other Attachment Form" and "Add Other Attachment." The header of the HRES should be clearly labeled as "Health Resource Equity Statement."

Budget Narrative

The Budget Narrative must be single-spaced and should follow the justifications and table formats provided in Section 5.1 Application Package, Subsection on Application Format. Detailed justifications must be provided for each activity, supply, or personnel proposed to be funded under this award along with full computations for budget estimates. Applicants must also clearly link each activity to the goals of this funding opportunity announcement and be consistent with Accountable Health Communities requirements. Overhead and administrative costs must be reasonable and are only reimbursable in accordance with grant policy. For more information on completing the budget narrative, please refer to Appendix 1: Sample Budget and Narrative Justifications.

Applicants should submit the Budget Narrative Attachment Form in the Grants Application Package at www.grants.gov; select the Budget Narrative Attachment Form and "Add Mandatory Budget Narrative." Completion of the Standard form, SF 424A, is also required.

For detailed application content, format and submission instructions, please refer to Appendix 2: Application and Submission Information.

Letter of Intent (Recommended)

Applicants are highly encouraged (but not required) to submit a non-binding Letter of Intent (LOI) to apply by February 8, 2016. Applicants submitting an application to two different AHC

tracks only need to submit one LOI and should select the tracks of interest on the LOI. Information from the LOI assists CMS with planning for the application review process. To submit your AHC LOI, please use the online LOI submission form located at: http://innovationgov.force.com/ahc.

5.3 Submission Dates and Times

All cooperative agreement applications must be submitted electronically and be received through http://grants.gov by 1:00 pm Eastern Standard Time, Thursday, March 31, 2016. Applications submitted after 1:00 pm, March 31st will not be reviewed or considered for cooperative agreement awards.

5.4 Intergovernmental Review

Applications for these cooperative agreements are not subject to review by states under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF 424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to these cooperative agreements.

5.5 Funding Restrictions

Direct Costs

Cooperative agreement funds may not be used to provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.

Reimbursement of Pre-Award Costs

No cooperative agreement funds awarded under this solicitation may be used to reimburse pre-award costs.

Prohibited Uses of Cooperative Agreement Funds

Use of cooperative agreement funds in the following ways will result in termination of the applicant's funding to implement the AHC model:

- To match any other Federal funds.
- To fund the provision of social services.
- To provide services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- To provide goods or services not allocable to the approved project.
- To supplant existing State, local, Tribal or private funding of infrastructure or services, such as staff salaries, etc.

- To be used by local entities to satisfy state matching requirements.
- To pay for construction.
- To pay for capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the Federal awarding agency.
- To pay for the cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
- To use as profit to any award recipient even if the award recipient is a commercial organization, (unallowable in accordance with 45 CFR 75.215(b)), except for grants awarded under the Small Business Innovative Research (SBIR) and Small Business Technology Transfer Research (STTR) programs (15 U.S.C. 638). Profit is any amount in excess of allowable direct and indirect costs.

6. Application Review Information

6.1 Criteria

This section fully describes the evaluation criteria for this cooperative agreement. In preparing applications, applicants should review the requirements detailed in Section 2. Funding Opportunity Description. The application must be organized as detailed in Section 5. Application Information of this solicitation.

Note to applicants:

- Review of the applicant's proposal and the geographic target area will be a variable in final determinations of award recipients. Only one award recipient, across any AHC intervention track, will be selected in a geographic target area.
- Applicants may apply for no more than two AHC intervention tracks. If an applicant chooses to apply for two tracks, they must submit two separate applications (one for each track).
- Applicants will not be funded to implement more than one AHC intervention track.
- Awards may be adjusted to a lower amount if the applicant fails to meet performance milestones (Refer to Table 3 Track 1 – Awareness Milestones and Deliverables, Table 4 Track 2 – Assistance Milestones and Deliverables, and Table 5 Track 3 – Alignment Milestones and Deliverables).

6.1.1 Project Abstract Summary (Required for all Applications)

(1 Page, single-spaced)

A one-page abstract should serve as a succinct description of the proposed project and should include the track the applicant is applying for, the goals of the project, the total budget, the number of projected community-dwelling beneficiary participants, and a description of how the funds will be used. The abstract is often distributed to provide information to the public and Congress, so please write the abstract so that it is clear, accurate, concise, and without reference

to other parts of the application. Personal identifying information should be excluded from the abstract.

Applicants should upload the abstract in the Grants Application Package which can be found at www.grants.gov; select the "Project Abstract Summary," and complete the form.

6.1.2 Project Narrative (Required for all Applications)

The review criteria for the Project Narrative are described below by intervention track. All elements of the Project Narrative, including the Implementation Plan (provided as a separate attachment) are required and will be used to assess an applicant's readiness to implement the intervention, the degree of overlap between existing services and the AHC intervention, knowledge of their community's services and capacity to support AHC model implementation and the depth of community relationships.

Project Narrative: Track 1 – Awareness (85 Points)

(35 Pages)

Track 1 – Awareness narrative must demonstrate the applicant's ability to increase community-dwelling beneficiaries' awareness of available community services through information dissemination and referral. Proposals must be well developed, detailed and clearly address each core element of the Awareness Intervention to receive full points. Track 1 – Awareness proposals will be evaluated based on the completeness of responses to each Project Narrative component presented in Section 5.2 Application Structure and Content and the details below. Application review panelists will score each proposal based on the quality of the response. Incomplete, unclear, and confusing proposals will receive point deductions. Project Narratives with significant content deficiencies may receive a score of zero. Proposals that repeat FOA content without demonstrating analysis and response to its content will receive a score of zero. Each component of the project narrative will be weighted as follows:

Table 14. Project Narrative: Track 1 – Awareness

Project Narrative Element	Selection Criteria	Points
A. Intervention Design – Core Elements		
1. Background	• Description of health-related social needs in the geographic target area • History of local interdisciplinary collaboration between clinical and community services • Description of how the applicant will use AHC funding to address the health-related social needs of its community-dwelling beneficiary population	5
2. Geographic Target Area	• Description of geographic area to be served • Summary of the number of community-dwelling beneficiaries served in the previous 12 months at clinical delivery sites (expectation will be to screen up to 75,000 community-dwelling beneficiaries per year) • Description of community resources and their capacity	10

Project Narrative Element	Selection Criteria	Points
	• List of supplemental health-related social needs to be addressed • Description of available community needs assessments and community action groups addressing health-related social needs	
3. Systematic Screenings for Health-related Social Need	• Plan for screening all community-dwelling beneficiaries seeking care at participating clinical delivery sites (i.e., protocols, clinical site coordination, and frequency of beneficiary screening) • Process for reporting data from screening tool to CMS, including reporting beneficiary information in real time in order to determine the community-dwelling beneficiary's intervention or control status	10
4. Community Resource Inventory	• Description of community services available related to core health-related social need domains • Description of community services available related to selected supplemental health-related social need domains • Description of data sources of Community Resource Inventory with specific reference to community services from the local Continuum of Care, 2-1-1 systems and Eldercare.gov • Description of adjustments to existing inventories necessary to address core or selected supplemental health-related social need domains	10
5. Tailored Community Referral Summary	• Description of tailored community referral summary content and organization • Description of referral logistics (i.e., protocols, identification of intervention/control participants, and distribution methodology)	10
B. Bridge Organization		
1. Background	• Description of capacity (i.e., history, ability, and commitment) to carry out core elements (described in Section 5.2 Application Structure and Content, Subsection on Stakeholder Engagement) • Description of process for data collection and reporting for internal quality control and CMS monitoring and evaluation	10
C. Stakeholder Engagement		
1. State Medicaid Agency	• Demonstrated alignment with Medicaid Agency • Description of capacity (i.e., history, ability, and commitment) to carry out core responsibilities (described in Section 5.2 Application Structure and Content, Subsection on State Medicaid Agency)	10
2. Consortium	• List of consortium participants or potential participants • Description of the flow of funding and data • Description of parameters of the intended relationship	10

Project Narrative Element	Selection Criteria	Points
	(i.e., roles and responsibilities) (described in Section 5.2 Application Structure and Content, Subsection on Consortium)	
3. Clinical Delivery Sites	• Description of capacity (i.e., history, ability, and commitment) to carry out core elements (described in Section 5.2 Application Structure and Content, Subsection on Clinical Delivery Sites) • Description of ability to screen and refer community-dwelling beneficiaries	10
Total Points		**85**

Project Narrative: Track 2 – Assistance (110 Points)

(45 Pages)

Track 2 – Assistance narrative must demonstrate the applicant's ability to assist high-risk community-dwelling beneficiaries with accessing community services through the support of AHC navigators. Proposals must be well developed, detailed and clearly address each core element of the Assistance Intervention to receive full points. Track 2 – Assistance proposals will be evaluated based on the completeness of responses to each Project Narrative component presented in Section 5.2 Application Structure and Content and the details below. Application review panelists will score each proposal based on the quality of the response. Incomplete, unclear, and confusing proposals will receive point deductions. Project Narratives with significant content deficiencies may receive a score of zero. Proposals that repeat FOA content without demonstrating analysis and response to its content will receive a score of zero. Each component of the project narrative will be weighted as follows:

Table 15. Project Narrative: Track 2 – Assistance

Project Narrative Element	Selection Criteria	Points
A. Intervention Design – Core Elements		
1. Background	• Description of health-related social needs in the geographic target area • History of local interdisciplinary collaboration between clinical and community services • Description of how the applicant will use AHC funding to address the health-related social needs of its community-dwelling beneficiary population	5
2. Geographic Target Area	• Description of geographic area to be served • Summary of the number of community-dwelling beneficiaries served in the previous 12 months at clinical delivery sites (expectation will be to screen up to 75,000 community-dwelling beneficiaries per year)	10

Project Narrative Element	Selection Criteria	Points
	• List of supplemental health-related social needs to be addressed • Description of available community needs assessments and community action groups addressing health-related social needs	
3. Systematic Screenings for Health-related Social Need	• Plan for screening all community-dwelling beneficiaries seeking care at participating clinical delivery sites (i.e., protocols, clinical site coordination, and frequency of beneficiary screening) • Process for reporting data from screening tool to CMS	10
4. Risk Stratification	• Plan for risk stratifying all community-dwelling beneficiaries based on number of ED visits in previous 12 months • Description of data, infrastructure, logistical challenges, and mitigation strategies related to risk stratification of all community-dwelling beneficiaries and proper placement of all community-dwelling beneficiaries in intervention, control, or non-intervention groups	5
5. Community Resource Inventory	• Description of community services available related to core health-related social need domains • Description of community services available related to selected supplemental health-related social need domains • Description of data sources of Community Resource Inventory with specific reference to community services from the local Continuum of Care, 2-1-1 systems and Eldercare.gov • Description of adjustments to existing inventories necessary to address core or selected supplemental health-related social need domains	10
6. Tailored Community Referral Summary	• Description of tailored community referral summary content and organization • Description of referral logistics (i.e., protocols, identification of intervention / control participants, and distribution methodology)	10
7. Navigation Services	• Description of process for conducting personal interviews, designing action plans, and following up with high-risk community-dwelling beneficiaries • Description of tools and process used to assess and track high-risk community-	10

Project Narrative Element	Selection Criteria	Points
	dwelling beneficiaries • Description of contact methodology and format	
B. Bridge Organization		
1. Background	• Description of capacity (i.e., history, ability, and commitment) to carry out core elements (described in Section 5.2 Application Structure and Content, Subsection on Stakeholder Engagement) • Description of process for data collection and reporting for internal quality control and CMS monitoring and evaluation	10
C. Stakeholder Engagement		
1. State Medicaid Agency	• Demonstrated alignment with Medicaid Agency • Description of capacity (i.e., history, ability, and commitment) to carry out core responsibilities (described in Section 5.2 Application Structure and Content, Subsection on State Medicaid Agency)	10
2. Consortium	• List of consortium participants or potential participants • Description of the flow of funding and data, including a plan for reporting funds used from all sources on AHC implementation to CMS • Description of parameters of the intended relationship (i.e., roles and responsibilities) (described in Section 5.2 Application Structure and Content, Subsection on Consortium)	10
3. Clinical Delivery Sites	• Description of capacity (i.e., history, ability, and commitment) to carry out core elements (described in Section 5.2 Application Structure and Content, Subsection on Clinical Delivery Sites) • Description of ability to screen and refer community-dwelling beneficiaries	10
4. Community Service Providers	• Description of process for tracking beneficiary utilization of community service provider resources and related outcomes • Description of capacity (i.e., history, ability, and commitment) to carry out core responsibilities (described in Section 5.2 Application Structure and Content, Subsection on Community Service Providers)	10

Project Narrative Element	Selection Criteria	Points
Total		**110**

Project Narrative – Track 3 – Alignment (145 Points)

(60 Pages)

Track 3 – Alignment narrative must demonstrate applicant's ability to (1) assist high-risk community-dwelling beneficiaries with accessing community services through the support of AHC navigators, and (2) align clinical and community resources. Proposals must be well developed, detailed and clearly address each core element of the Alignment Intervention to receive full points. Track 3 – Alignment proposals will be evaluated based on the completeness of responses to each Project Narrative component presented in Section 5.2 Application Structure and Content and the details below. Application review panelists will score each proposal based on the quality of the response. Incomplete, unclear, and confusing proposals will receive point deductions. Project Narratives with significant content deficiencies may receive a score of zero. Proposals that repeat FOA content without demonstrating analysis and response to its content will receive a score of zero. Each component of the project narrative will be weighted as follows:

Table 16. Project Narrative: Track 3 – Alignment

Project Narrative Element	Selection Criteria	Points
A. Intervention Design – Core Elements		
1. Background	• Description of health-related social needs • History of local interdisciplinary collaboration between clinical and community services • Description of how the applicant will use AHC funding to address the health-related social needs of its community-dwelling beneficiary population	5

Project Narrative Element	Selection Criteria	Points
2. Geographic Target Area	• Description of geographic area being served • Summary of the number of community-dwelling beneficiaries served in the previous 12 months at clinical delivery sites (expectation will be to screen up to 75,000 community-dwelling beneficiaries per year) • List of Medicare Advantage and Medicaid Managed Care penetration rates • Ability to serve 51 percent of community-dwelling beneficiaries • Description of community resources and their capacity • List of supplemental health-related social needs to be addressed • Description of available community needs assessments and community action groups addressing health-related social needs • Description of the community's commitment to the AHC intervention and goals	10
3. Systematic Screenings for health-related social need	• Plan for screening all community-dwelling beneficiaries seeking care at participating clinical delivery sites (i.e., protocols, clinical site coordination, and frequency of beneficiary screening) • Process for reporting data from screening tool to CMS	10
4. Risk Stratification	• Plan for risk stratifying all community-dwelling beneficiaries based on number of ED visits in previous 12 months • Description of data, infrastructure, and logistical challenges and mitigation strategies related to risk stratification of all community-dwelling beneficiaries and proper placement of all community-dwelling beneficiaries in intervention, control, or non-intervention groups	5
5. Community Resource Inventory	• Description of community services available related to core health-related social need domains • Description of community services available related to selected supplemental health-related social need domains • Description of data sources of Community Resource Inventory with specific reference to community services from the local Continuum of Care and 2-1-1 systems and Eldercare.gov • Description of adjustments to existing inventories necessary to address core or selected supplemental health-related social need domains	15
6. Tailored Community Referral Summary	• Description of tailored community referral summary content and organization • Description of referral logistics (i.e., protocols, identification of intervention/control participants, and distribution methodology)	10

Project Narrative Element	Selection Criteria	Points
7. Navigation Services	• Description of process for conducting personal interviews, designing action plans, and following-up with high-risk community-dwelling beneficiaries • Description of tools and process used to assess and track all community-dwelling beneficiaries • Description of contact methodology and format	10
B. Bridge Organization		
1. Background	• Description of capacity (i.e., history, ability, and commitment) to carry out core elements (described in Section 5.2 Application Structure and Content, Subsection on Stakeholder Engagement), in addition to serving as the Community Integrator and convening an advisory board • Description of process for data collection and reporting for internal quality control and CMS monitoring and evaluation	10
C. Stakeholder Engagement		
1. State Medicaid Agency	• Demonstrated alignment with Medicaid Agency • Description of capacity (i.e., history, ability, and commitment) to carry out core responsibilities (described in Section 5.2 Application Structure and Content, Subsection on State Medicaid Agency)	10
2. Consortium	• List of consortium participants or potential participants • Description of the flow of funding and data, • Description of parameters of the intended relationship (i.e., roles and responsibilities) (described in Section 5.2 Application Structure and Content, Subsection on Consortium)	10
3. Clinical Delivery Sites	• Description of capacity (i.e., history, ability, and commitment) to carry out core responsibilities Description of capacity (i.e., history, ability, and commitment) to carry out core elements (described in Section 5.2 Application Structure and Content, Subsection on Clinical Delivery Sites) • Description of ability to screen and refer community-dwelling beneficiaries	10
4. Community Service Providers	• Description of process for tracking community-dwelling beneficiary utilization of community service provider resources and related outcomes • Description of capacity (i.e., history, ability, and commitment) to carry out core responsibilities (described in Section 5.2 Application Structure and Content, Subsection on Community Service Providers)	10

Project Narrative Element	Selection Criteria	Points
D. Community Integrator		
1. Advisory Board	• Description and intended composition of advisory board • Contracts, MOUs or MOU equivalents with each participating (and intended participating) entity • Overview of advisory board structure including frequency of meetings, decision making process and roles in intervention management	10
2. Data Sharing	• Plan for tracking and reporting on key data points including each community-dwelling beneficiary's service use and costs across care settings pertinent to this model (i.e., clinical and community services being accessed) and capacity of community service providers	10
3. Gap Analysis	• Gap analysis plan detailing how the bridge organization expects to collect and analyze information to identify gaps in community service capacity, including data about social needs identified through the screening tool • Robust description of data sources including currently available local data and assessments related to clinical health and health-related social needs • Description of bridge organization's experience with similar efforts	5
4. Quality Improvement Plan	• Description of how the bridge organization will develop a plan for quality improvement, including goals, terminology, management, monitoring and QI methodology and quality assurance • Description of existing quality improvement initiatives and activities that are relevant to the AHC model and how they can be leveraged to support the quality improvement activities of the model • Description of bridge organization's experience with similar efforts	5
Total		**145**

6.1.3 Additional Required Documentation (Required for all Applications)

Implementation Plan **8 Points**

(10 pages for Tracks 1; 12 pages for Track 2; 15 pages for Track 3)

The applicant shall submit a detailed Implementation Plan that describes how the applicant intends to implement the track to which it is applying and: (1) implement the AHC intervention as intended, (2) achieve track-specific milestones, and (3) engage in quality improvement. The Implementation Plan shall be evaluated based on the inclusion of and adequacy in addressing the information listed in Section 5.2 Application Structure and Content, Subsection on Implementation Plan.

Contract, MOU or MOU Equivalent with State Medicaid Agency **25 Points**

One contract, MOU or MOU equivalent from each state Medicaid agency involved with the intervention shall be submitted. Each contract, MOU or MOU equivalent shall be evaluated based on the inclusion of and adequacy in addressing the information listed in Section 5.2 Application Structure and Content, Subsection on Contract, MOU or MOU Equivalent with State Medicaid Agency.

Contracts, MOUs or MOU Equivalents with Clinical Delivery Sites **15 Points**

Each applicant must submit a minimum of one contract, MOU or MOU equivalent from each of the following: hospital, primary care practice or provider that furnishes primary care services, and behavioral health provider. Each contract, MOU or MOU equivalent shall be evaluated based on the inclusion of and adequacy in addressing the information listed in Section 5.2 Application Structure and Content, Subsection on Contracts, MOUs or MOU Equivalents with Clinical Delivery Sites.

Contracts, MOUs or MOU Equivalents with Community Service Providers (Track 3 only) **10 Points**

A contract, MOU or MOU equivalent from each community service provider is required for Track 3 advisory board participants and recommended for community service providers who will participate with Track 1 and 2 applicants. Each contract, MOU or MOU equivalent shall be evaluated based on the inclusion of and adequacy in addressing the information listed in Section 5.2 Application Structure and Content, Subsection on Contracts, MOUs or MOU Equivalents with Community Service Providers.

Assessment of Program Duplication **0 Points**

(2 pages per checklist/ No maximum number of checklists)

The bridge organization must submit, as an appendix to the applicant's implementation plan, an Assessment of Program Duplication for each program identified as potentially duplicative and a plan for avoiding duplication. The Assessment will compare existing programs to the AHC requirements and protocols as outlined in the FOA and identify overlaps and gaps. Each assessment shall not exceed 2 pages. All assessments should be included in one document and signed by the state Medicaid agency designee (with respect to potential Medicaid duplication) and the bridge organization. See Appendix 7: Assessment of Program Duplication for a template.

Health Resource Equity Statement **2 Points**

(3 pages)

The applicant must submit a Health Resource Equity Statement (HRES) (also known as a Disparities Impact Statement) as an appendix of the applicant's implementation plan. Applicants should collaborate with their model participants to develop the HRES. The HRES should include: a statement of need, an action plan, and a performance assessment and data summary. See Appendix 8: Health Resource Equity Statement for a template.

Budget Narrative **15 Points**

(15 pages)

The budget narrative should be developed to be consistent with the AHC proposal requirements. Budgets and budget narratives must support the intervention track description the applicant is proposing to implement outlined in Section 2.4 Program Requirements. Budgets and budget narratives should consider Section 2.4.1.1 Model Track Proposal Requirements – All Tracks, Subsection on Key Personnel. All direct and indirect (F&A) costs must be reasonable, allowable, allocable and necessary. See Appendix 1: Sample Budget and Narrative Justifications for more information.

Table 17. Additional Required Documentation

Additional Required Documentation	Points
Implementation Plan	8
Contracts, MOUs or MOU equivalents with State Medicaid Agencies	25
Contract(s), MOU(s) or MOU equivalent(s) with Hospital(s)	5
Contract(s), MOU(s) or MOU equivalent(s) with Primary Care Provider(s)	5
Contract(s), MOU(s) or MOU equivalent(s) with Behavioral Health Service Provider(s)	5
Contract(s), MOU(s) or MOU equivalent(s) with Community Service Provider(s)	5
Health Resource Equity Statement	2
Assessment of Program Duplication	0
Budget Narrative	15
Total Points	70

6.2 Review and Selection Process

A team consisting of qualified experts will review the applications to assess the degree of responsiveness and clarity in the proposal. There will be a separate review process for Track 1– Awareness, Track 2 – Assistance, and Track 3 – Alignment. CMS will work closely with the applicant to determine the appropriate funding amount for the award. The review process will include the following:

- Applications will be screened for completeness and adherence to eligibility requirements for the Track to which the applicant has applied: Track 1– Awareness, Track 2 – Assistance, or Track 3 – Alignment. Applications that are received late, fail to meet the eligibility requirements detailed in this solicitation, are incomplete, or do not include the required forms will not be reviewed.

- An objective review panel will be convened to determine the merits of each application and the extent to which the proposed intervention is structured to further the purpose of the AHC model. The objective review panel may include both federal employees and non-federal employees. In addition to the review panel, CMS will provide an assessment of the applicant's readiness to implement the AHC intervention. CMS reserves the right to request that applicants revise or otherwise modify their proposals and budget based on CMS recommendations.

The results of the objective review panels will be used to advise the CMS approving official. Final award decisions will be made by the designated approving official. In making these decisions, the CMS approving official will take into consideration:

- Recommendations of the objective review panel,
- Geographic diversity of award recipients,
- Readiness to conduct the AHC intervention,
- Scope of impact in the geographic target area,
- Responsiveness to CMS's inquiries and clarifications to application,
- Reviews for programmatic grants management and other compliance, and
- Reasonableness of the estimated cost to the government and anticipated cost.

Successful applicants will receive one cooperative agreement award issued under this announcement. CMS intends to fund projects in communities with a wide variety of geographic and social-economic characteristics, including underserved urban and rural areas. In determining which applications to recommend, award recipients may be funded based on program balance, priorities, and goals. Note that section 1115A(d)(2) of the Social Security Act specifies that there is no administrative or judicial review of the selection of organizations, sites, or participants to test models.

6.3 Anticipated Award Date

See Section 1. Executive Summary for anticipated award date.

7. Award Administration Information

7.1 Award Notices

Award recipients will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer via GrantSolutions. The NoA is the legal document authorizing funding for a successful application and will be sent by electronic mail to the award recipient as listed on its SF-424. Any communication between CMS and applicants prior to issuance of the NoA is not approval or authorization to begin performance of a project.

Unsuccessful applicants will be notified by letter, sent electronically or through the U.S. Postal Service to the applicant organization as listed on its SF-424 within 30 days of the award date.

7.2 Administrative and National Policy Requirements

Among other legal requirements, the following standard requirements apply to applications and awards under this FOA:

- Specific grant administrative requirements, as outlined in 2 CFR Part 200 and 45 CFR Part 75, apply to FOA.
- All award recipients receiving awards under this cooperative agreement project must comply with all applicable Federal statutes relating to nondiscrimination, including, but not limited to:
  - Title VI of the Civil Rights Act of 1964
  - Section 504 of the Rehabilitation Act of 1973
  - The Age Discrimination Act of 1975, and
  - Title II, Subtitle A of the Americans with Disabilities Act of 1990.
- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original grant application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.
- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.

Accessibility Provisions for All Grant Application Packages and Funding Opportunity Announcements

Award recipients, as recipients of federal financial assistance (FFA) from Health and Human Services (HHS), must administer their programs in compliance with federal civil rights laws. This means that award recipients must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age and, in some circumstances, sex and religion. It is HHS' duty to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations.

HHS provides guidance to award recipients on meeting their legal obligation to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency. In addition, award recipients will have specific legal obligations for serving qualified individuals with disabilities by providing information in alternate formats.

Several sources of guidance provided below:

1. http://www.hhs.gov/civil-rights/for-providers/index.html
2. http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html
3. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53
4. http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html
5. HHSAR 352.270-1
6. http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html or call 1-800-368-1019 or TDD 1-800-537-7697.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements.

This award is subject to 45 CFR Part 75 [available at http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5], which implements 2 CFR Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance") for the Department of Health and Human Services operating divisions, effective December 26, 2014.

Uniform Administrative Requirements. All award recipients must comply with Subparts A-D of 45 CFR Part 75. These include:

- **Cost Principles.** CMS grant awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a particular set of cost principles depends on the type of organization. Award recipients must comply with the cost principles set forth in HHS regulations at 45 CFR Part 75, Subpart E with the following exceptions: (1) hospitals must follow Appendix IX to part 75 and commercial (for-profit) organizations are subject to the cost principles located at 48 CFR subpart 31.2.
- There are no cost principles specifically applicable to grants to commercial organization (for-profit organizations). Therefore, the cost principles for commercial organizations set forth in the FAR (48 CFR subpart 31.2) generally are used to determine allowable costs under CMS grants to for-profit organizations. As provided in those costs principles, allowable travel costs may not exceed those established by the FTR (available on-line at Direct and Indirect Costs: There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities &Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost in order to avoid double-charging of Federal awards. Guidelines for determining direct and F&A costs charged to Federal awards are provided in §§75.412 to 75.419, well as Appendices III, IV, VII, IX to Part 75.

Indirect Costs

If an applicant is requesting indirect costs, they are required to use a current negotiated indirect cost rate (NICRA). These agreements are typically negotiated by: HHS Cost Allocation Services (CAS) (https://rates.psc.gov/fms/dca/orgmenu1.html) and Office of Naval Research (ONR) (http://www.onr.navy.mil/Contracts-Grants/manage-grant/indirect-cost-proposal.aspx). Any non-Federal entity that has never received a negotiated indirect cost rate, in except for those non-Federal entities described in appendix VII to part 75 (D)(1)(b) may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC) which may be used indefinitely.

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. For-profit organizations must still obtain a negotiated indirect cost rate agreement which covers the grant supported activities. Indirect cost rate agreements which exclusively cover contracts will not be acceptable. For-profit entities which receive the preponderance of their federal awards from HHS may contact the Division of Financial Advisory Services (DFAS), Indirect Cost Branch, available at http://oamp.od.nih.gov/dfas/indirect-cost-branch to negotiate an indirect cost rate. Otherwise, for-profit organizations are limited to the 10% de minimis rate in accordance with 45 CFR §75.414(f).

Cost Allocation: In accordance with 45 CFR §75.416 and Appendix V to Part 75 – *State/Local Government wide Central Service Cost Allocation Plans*, each state/local government will submit a plan to the Department of Health and Human Services Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the Department of Health and Human Services entitled "*A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*." A copy of this brochure may be obtained from the HHS' Cost Allocation Services at https://rates.psc.gov. A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Appendix VI to Part 75 – *Public Assistance Cost Allocation Plans*, state public assistance agencies will develop, document and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the provisions of Subpart E of 45 CFR part 95.

Audit Requirements.

The audit requirements in 45 CFR Part 75, Subpart F apply to each award recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F, *Audit Requirements*.

Commercial Organizations (including for-profit hospitals) have two options regarding audits, as outlined in 45 CFR §75.501 (see also 45 CFR §75.215).

7.3 Terms and Conditions

This announcement is subject to the requirements of the HHS Grants Policy Statement that are applicable to the award recipient based on the award recipient's type and the purpose of this award [available at http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf]. The general terms and conditions in the HHS Grants Policy Statement will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary. Although the HHS Grants Policy Statement is meant to be consistent with applicable statutory or regulatory requirements, the current 2007 version has not been updated to parallel the new HHS regulations. The new HHS regulation, effective December 26, 2014, therefore supersedes information on

administrative requirements, cost principles, and audit requirements for grants and cooperative agreement included in the current HHS Grants Policy Statement where differences are identified. CMS may terminate any award for material noncompliance in accordance with grant regulation. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

Conflict of Interest Policies. In accordance with 45 CFR §75.112, all award recipients receiving federal funding from CMS must establish and comply with the conflict of interest policy requirements outlined by CMS (available upon request).

Mandatory Disclosures. As is stated under 45 CFR §75.113, award recipients must disclose, prior to award, in writing to CMS or the pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures can result in any of the remedies described in §75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. 3321).

In the event an award recipient or one of its sub- award recipients enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the award recipient agrees to provide written notice of the bankruptcy to CMS. This written notice shall be furnished within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, a copy of any and all of the legal pleadings, and a listing of Government grant and cooperative agreement numbers and grant offices for all Government grants and cooperative agreements against which final payment has not been made.

7.4 Cooperative Agreement Terms and Conditions of Award

The administrative and funding instrument used for Accountable Health Communities will be a cooperative agreement, an assistance mechanism in which substantial CMS programmatic involvement with the award recipient is anticipated during the performance of the activities. Under each cooperative agreement, CMS's purpose is to support and stimulate the award recipient's activities by involvement in, and otherwise working jointly with, the award recipient in a partnership role.

CMS will have substantial involvement in program awards, as outlined below:

- Technical Assistance – CMS will host opportunities for training and/or networking, including conference calls and other vehicles.
- Collaboration – To facilitate compliance with the terms of the cooperative agreement and to support award recipients more effectively, CMS will actively coordinate with other relevant Federal Agencies.
- Program Evaluation – CMS will work with award recipients to implement lessons learned.
- Project Officers and Monitoring – CMS will assign specific Project Officers to each cooperative agreement award to support and monitor award recipients throughout the period of performance. CMS Grants Management Officers, Grants Management

Specialists, and Project Officers will monitor, on a regular basis, progress of each award recipient. This monitoring may be by phone, document review, on-site visit, other meeting, and by other appropriate means, such as reviewing program progress reports and Federal Financial Reports (FFR or SF-425). This monitoring will be to determine compliance with programmatic and financial requirements.

Award Recipients

Award recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the cooperative agreement and with substantial CMS involvement. Award recipients shall engage in the following activities:

- Reporting – comply with all reporting requirements outlined in this funding opportunity and the terms and conditions of the cooperative agreement to ensure the timely release of funds.
- Program Evaluation – cooperate with HHS-directed national program evaluations.
- Technical Assistance – participate in technical assistance venues as appropriate.
- Program Standards – comply with all Accountable Health Communities requirements, applicable current and future standards, as detailed in regulations, guidance, and the cooperative agreement terms and conditions provided with the NoA.

Intellectual Property

In accordance with §75.322(c), all award recipients are subject to applicable regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR part 401. For further guidance, please see the HHS Grants Policy Statement, Patents and Inventions, and Inventions Reporting sections.

7.5 Reporting

All award recipients under this announcement must comply with the following reporting and review activities:

7.5.1 Progress Reports

Award recipients must agree to cooperate with any Federal evaluation of Accountable Health Communities and, in addition to other reporting requirements, will be expected, at a minimum, to provide quarterly and final (at the end of the performance period) reports, as required, in the format prescribed by CMS. To facilitate programmatic involvement of CMS, additional information on program progress may be requested in written or verbal formats during monthly progress meetings. Programs not meeting programmatic milestones may be required to provide more frequent progress updates as a result of a corrective action. Reports will be submitted electronically. Programs should be prepared to report quarterly on each intervention element and their program's progress towards goals. The program progress narrative report elements include but are not limited to:

i. Program Name

ii. Program Leader Name

iii. Reporting Period

iv. Budget Status – include amounts for planned expenditure, actual expenditure, and deficit/surplus

v. Work Plan Chart/Timeline status

vi. Project description –- short summary

vii. Milestones - Milestones are high-level goals that often define the phases of a project. Record here milestones that have been reached at this point in the project

viii. Accomplishments – Tasks that were accomplished during this reporting period

ix. Projected Goals – Goals projected to be completed during the next reporting period, and

x. Issues – Issues that must be addressed for the project to be successful

The anticipated due date for the first year-end narrative reports is March 31, 2018. Quarterly program progress reports (PPRs) for future budget periods will be due within 30 days of each quarterly period with the submission of the non-compete continuation award application.

The anticipated due date for the final progress report is March 31, 2022, 90 days after the end of the project period.

Federal Financial Report, SF-425(FFR)

Additional information on financial reporting will be provided in the terms and conditions of award.

Federal Funding Accountability and Transparency Act Reporting Requirements

New awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Award recipients must report information for each first-tier sub-award of $25,000 or more in Federal funds and executive total compensation for the award recipient and sub-award recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at https://www.fsrs.gov/).

8. Agency Contacts

8.1 Programmatic Questions

For programmatic questions about this cooperative agreement, please contact:

Susan Jackson

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

E-mail: accountablehealthcommunities@cms.hhs.gov

8.2 Administrative Questions

For administrative questions about this cooperative agreement please contact:

Louise M Amburgey

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

E-mail: OAGM-AHC@cms.hhs.gov

9. Appendices

9.1 Appendix 1: Sample Budget and Narrative Justifications

Detailed Budget and Expenditure Plan

All applicants must submit Form SF 424A and a Budget Narrative Attachment Form. For this cooperative agreement, the application must include budgets for each year. Costs must be reasonable with a strong focus on operational implementation of the model. Budget and Expenditure Plans should include the cost of data collection, performance monitoring, and project expenditure reporting. No funding for this model, other than funding provided under this cooperative agreement, is permitted.

In addition, applicants must supplement Budget Form SF 424A with a Budget Narrative. The Budget Narrative must include a yearly breakdown of costs for the entire project period. Specifically the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF 424A by year, including a breakdown of costs for each activity/cost within the line item. The Budget Narrative should reflect the organization's readiness to receive funding, providing complete explanations and justifications for the proposed cooperative agreement activities.

All applicants must submit an SF 424A. To fill out the budget information requested on form SF 424A, review the general instructions provided for form SF 424A and follow the instructions outlined below.

Section A – Budget Summary

- *Grant Program Function or Activity* (column a) = Enter "Accountable Health Communities" in row 1.
- *New or Revised Budget, Federal* (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
- *New or Revised Budget, Total* (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal Total.

Section B – Budget Categories

- Total Costs Requested: Enter the total costs requested for each Object Class Category (Section B, number 6) for each year of the five-year project period. In order to enter information for all five years, a second SF 424A form will need to be used.
- Column (1) = Enter the heading for this column as Year 1. Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all year 1 line items should be entered in column 1, row k (sum of row i and j).
- Column (2) = Enter the heading for this column as Year 2. Enter Year 2 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for direct and indirect charges for all Year 2 line items should be entered in column 2, row k (sum of row i and j).

- Column (3) = Enter the heading for this column as Year 3. Enter Year 3 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all Year 3 line items should be entered in column 3, row k (sum of row i and j).
- Column (4) = Enter the heading for this column as Year 4. Enter Year 4 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all Year 4 line items should be entered in column 3, row k (sum of row i and j).
- Column (1) –second form = Enter the heading for this column as Year 5. Enter Year 5 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges should be reflected in row j. The total for all Year 5 line items should be entered in column 3, row k (sum of row i and j).
- Column (5) –second form = Enter the heading for this column as Total Costs. Enter total costs for all five years of the project period for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items for the five years should be entered in row k (sum of row i and j). The total in column 8, row k should match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Allowable Costs

Allowable costs include (but are not limited to): staff participation and travel to learning collaborative, workshops, and other learning and diffusion opportunities. All travel must include information as to who is traveling, where, flight or mileage, per diem, hotel, etc. Information as to how the travel is necessary to achieve the goals of the program must also be included. Travel costs must be reasonable and consistent with the non-Federal entity's established travel policy.

Detailed costs and breakdown for each SF 424A line item:

A. Personnel:

These are employees of the applying agency whose work is tied to the application.

Table 18. Example Federal Request

Position	Name	Annual Salary/Rate	Level of Effort	Cost
Program Director	John Doe	$150,000	10%	$15,000
Project Coordinator	To be selected	$50,000	100%	$50,000
TOTAL				$65,000

NARRATIVE JUSTIFICATION: Enter a description of the personnel funds requested and how their use will support the purpose and goals of this proposal. Be sure to describe the role, responsibilities and unique qualifications of each position. For each requested position, provide

the following information: name of staff member occupying the position (if available), annual salary, percentage of time budgeted for this program, and cost of salary to the project.

Note: Consistent with Consolidated and Further Continuing Appropriations Act, 2015 Public Law 113-235, Division G, Title II, General Provisions, Section 203, none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II. This salary cap applies to direct salaries and to those salaries covered under indirect costs, also known as facilities and administrative (F & A) costs. The current Executive Level II salary rate is $183,300.

FEDERAL REQUEST (enter in Section B column one line 6a of form SF424A for Year 1): **$65,000**

B. Fringe Benefits:

Fringe benefits may include contributions for social security, employee insurance, pension plans, etc. Only those benefits not included in an organization's indirect cost pool may be shown as direct costs. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. List all components of the fringe benefits rate.

Table 19. Example Federal Request

Component	Rate	Wage	Cost
FICA	7.65%	$65,000	$4,973
Workers Compensation	2.5%	$65,000	$1,625
Insurance	10.5%	$65,000	$6,825
TOTAL			$13,423

NARRATIVE JUSTIFICATION: Enter a description of the fringe funds requested, how the rate was determined, and how their use will support the purpose and goals of this proposal.

FEDERAL REQUEST (enter in Section B column one line 6b of form SF424A)**: $13,423**

C. Travel:

Explain the need for all travel. The lowest available commercial fares for coach or equivalent accommodations must be used. Do not exceed GSA rates.

(1) Elaborate and justify the necessity of the travel/training/conference.

(2) For each occurrence, please provide the following:

- A copy of the agenda/training syllabus.
- Names of staff that will be traveling.
- How will this travel/conference/training impact the implementation of the program? Is it necessary to implement the award?
- Travel costs (mileage, flight, hotel, and per diem), etc.

(3) What evaluation mechanism will be used to determine the impact of this training/conference on the outcomes of the award?

If approved, a conference summary is required 30 days after the meeting date. A summary should respond to the following questions/comments:

- What impact did this training/conference have on our project?
- In what ways will these changes affect our project outcomes?
- The annual report should include follow-up information as to whether or not these changes were realized.

Table 20. Example Federal Request

Purpose of Travel	Location	Item	Rate	Cost
Site Visits	Neighboring areas of XXX	Mileage	$0.575 x 49 miles	$28
Training (name)	Chicago, IL	Airfare	$200/flight x 2 persons	$400
Training (name)	Chicago, IL	Hotel	$140/night x 2 persons x 3 nights	$840
Training (name)	Chicago, IL	Per Diem (meals)	$49/day x 2 persons x 4 days	$392
TOTAL				$1,660

NARRATIVE JUSTIFICATION: Describe the purpose of travel and how costs were determined. See below CMS travel/conference guidelines.

FEDERAL REQUEST (enter in Section B column 1 line 6c of form SF424A): **$1,660**

D. Equipment:

Permanent equipment is defined as nonexpendable personal property having a useful life of more than one year and an acquisition cost of $5,000 or more. If applicant agency defines “equipment” at lower rate, then follow the applying agency’s policy.

Table 21. Example Federal Request

Item(s)	Rate	Cost
None		0
TOTAL		

NARRATIVE JUSTIFICATION: Enter a description of the Equipment and how its purchase will support the purpose and goals of this proposal.

FEDERAL REQUEST (enter in Section B column 1 line 6d of form SF424A): **$ 0**

E. Supplies: Materials costing less than $5,000 per unit and often having one-time use.

Table 22. Example Federal Request

Item(s)	Rate	Cost
General office supplies	$50/mo. x 12 mo.	$600
Postage	$50/mo. x 12 mo.	$600
Laptop Computer	$500 x 2	$1000
Printer	$300	$300
Cell Phones	$100 x 2	$200
Copies	8000 copies x $0.10/copy	$800
Computer update (if needed)		$477
TOTAL		$3,977

NARRATIVE JUSTIFICATION: Enter a description of the supplies requested and how their purchase will support the purpose and goals of this proposal. For all electronic and computing devices (laptops, tablets, cell phones, etc.) under the $5,000 threshold, a control system must be developed to ensure adequate safeguards to prevent loss, damage, or theft of the property. This control system should include any information necessary to properly identify and locate the item. For example: serial # and physical location of laptops and tablets. Please list staff assignments and percent of effort for laptops, iPads, cell phones, etc.

FEDERAL REQUEST (enter in Section B column 1 line 6e of form SF424A): **$3,977**

F. Consultant/Sub-Award Recipient/Contractual Costs:

The costs of project activities to be undertaken by a third-party sub-award recipient should be included in this category as a single line item charge. Please see 45 CFR Part 75.351 Sub-award recipient and contractor determinations. Award recipients must submit to CMS the required information establishing a third-party sub-award/contract to perform program activities, and a complete itemization of the costs should be attached to the budget. If there is more than one sub-award recipient/contractor, each must be budgeted separately and must have an attached itemization. A consultant is a non-employee who provides advice and expertise in a specific program area. Hiring a consultant requires submission of consultant information to HHS.

Required Reporting Information for Consultant Hiring

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g., training, expert consultant, etc.) for a fee and who is not an employee of the grantee organization. Submit the following required information for consultants:

(1) *Name of Consultant*: Identify the name of the consultant and describe his or her qualifications.

(2) *Organizational Affiliation*: Identify the organizational affiliation of the consultant, if applicable.

(3) *Nature of Services to be Rendered*: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables. A copy of the actual consultant agreement should not be sent to HHS.

(4) *Relevance of Service to the Project*: Describe how the consultant services relate to the accomplishment of specific program objectives.

(5) *Number of Days of Consultation*: Specify the total number of days of consultation.

(6) *Expected Rate of Compensation:* Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.

(7) *Justification of expected rates*: Provide a justification for the rate, including examples of typical market rates for this service in your area.

(8) *Method of Accountability*: Describe how the progress and performance of the consultant will be monitored. Identify who is responsible for supervising the consultant agreement.

If the above information is unknown for any contractor at the time the application is submitted, the information must be estimated and itemized as noted above. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

Required Information for Sub-Award Recipient Approval

Provide the expected Statement of Work, Period of Performance and how the proposed costs were estimated using the same format and detailed cost itemization as instructed above for the primary applicant using a the SF-424A for each participating sub-award recipient.

Required Information for Contract Approval

All award recipients must submit to CMS the following required information for establishing a third-party contract to perform project activities.

(1) *Name of Contractor:* Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.

(2) *Method of Selection:* How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.

(3) *Period of Performance:* How long is the contract period? Specify the beginning and ending dates of the contract.

(4) *Scope of Work:* What will the contractor do? Describe in outcome terms the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives. Deliverables should be clearly defined.

(5) *Method of Accountability:* How will the contractor be monitored? Describe how the progress and performance of the contractor will be monitored during and on close of the contract period. Identify who will be responsible for supervising the contract.

(6) *Itemized Budget and Justification*: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

If the above information is unknown for any contractor at the time the application is submitted, the information must be estimated and itemized as noted above. Copies of the actual contracts should not be sent to HHS, unless specifically requested. In the body of the budget request, a summary should be provided of the proposed contracts and amounts for each.

Table 23. Example Federal Request

Name	Description	Cost
1. To be selected	Environmental Strategy Consultation Rate is $150/day for 40 days = $6,000 Travel 175 miles @ .575/mile = $100	$6,100
2. To be selected	Media 1.5 minute Public Service Announcement (PSA)	$3,000
3. To be selected	Evaluation Report	$4,000
4. To be selected	Training for Staff members Trainers: rate is $300/day for 4 days = $1,200 Materials: approx. $5/person X 25 people = $125 Room Rental = $75 Travel for Trainers = Flight $300/person X 2 people = $600 Per Diem - $50/day x 4 days x 2 people = $400	$2,400
5. To be selected	Data Analysis	$2,000
6. To be selected	Responsible Server Training Trainer: rate $500/day	$500
7. To be selected	Television advertising to run ads 5x/week x $50/ad X 52 wks.	$13,000
TOTAL		$31,000

NARRATIVE JUSTIFICATION: Explain the need for each agreement and how their use will support the purpose and goals of this proposal. For those contracts already arranged, please provide the proposed categorical budgets. For those subcontracts that have not been arranged, please provide the expected Statement of Work, Period of Performance and how the proposed costs were estimated and the type of contract (bid, sole source, etc.).

FEDERAL REQUEST (enter in Section B column 1 line 6f of form SF424A): **$31,000**

G. Other: Expenses not covered in any of the previous budget categories.

Table 24. Example Federal Request

Item	Rate	Cost
1. Rent	$500/mo. x 12 mo.	$6,000
2. Telephone	$100/mo. x 12 mo.	$1,200
3. Student Surveys	$1/survey x 3000	$3,000
4. Brochures	.80/brochure X 1500 brochures	$1,200
5. Web Service	$100/mo. x 12 mo.	$1,200
TOTAL		$12,600

NARRATIVE JUSTIFICATION: Explain the need for each item and how their use will support the purpose and goals of this proposal. Be sure to break down costs into cost/unit: i.e., cost/square foot and explain the use of each item requested.

FEDERAL REQUEST (enter in Section B column 1 line 6h of form SF424A): **$12,600**

H. Total Direct Charges: Sum of Total Direct Costs

FEDERAL REQUEST (enter in Section B column 1 line 6i of form SF424A)

I. Indirect Charges:

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement (NICRA) (see Section 7.2 Administrative and National Policy Requirements: Indirect Cost Rates.). Any non-Federal entity that has never received a negotiated indirect cost rate, except for those non-Federal entities described in except for those non-Federal entities described in appendix VII to part 75 (D)(1)(b) may elect to charge a de minimis rate of 10 percent of modified total direct costs (MTDC) which may be used indefinitely. If a rate has been issued, a copy of the most recent NICRA must be provided with the application.

Sample Budget

The rate is ___% and is computed on the following direct cost base of $_____.

Personnel $_____

Fringe $_____

Travel $_____

Supplies $_____

Other $_____

Total $_____ x ___% = Total Indirect Costs

FEDERAL REQUEST (enter in Section B column 1 line 6j of form SF424A)

J. TOTALS: Sum of Total Direct Costs and Indirect Costs for Year 1

FEDERAL REQUEST (enter in Section B column 1 line 6k of form SF424A)

Program Income

Application must indicate whether program income is anticipated. If program income is anticipated, use the format below to reflect the amount and sources(s).

Budget Period:

Anticipated Amount:

Sources:

Anticipated Use:

9.2 Appendix 2: Application and Submission Information

Employer Identification Number

All applicants must have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), assigned by the Internal Revenue Service. All applicants under this announcement must have an Employer Identification Number/Taxpayer Identification Number (EIN/TIN) to apply. **Please note that applicants should begin the process of obtaining an EIN/TIN as soon as possible after the announcement is posted to ensure this information is received in advance of application deadlines.**

Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number)

All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. A DUNS number must be provided in order to submit an application through the government-wide electronic portal, www.grants.gov. The DUNS number is a nine-digit identification number that uniquely identifies business entities. To obtain a DUNS number, access the following website: www.dnb.com or call 1-866-705-5711. This number should be entered in the block with the applicant's name and address on the cover page of the application (Item 8c on the Form SF424, Application for Federal Assistance). The organization name and address entered in block 8a and 8e should be exactly as given for the DUNS number**. Applicants should obtain this DUNS number as soon as possible after the announcement is posted to ensure all registration steps are completed in time.**

System for Award Management (SAM)

All applicants must register in the System for Award Management (SAM)* database (https://www.sam.gov/portal/public/SAM/) in order to be able to submit an application at http://www.grants.gov. In order to register, applicants must provide their DUNS and EIN numbers. Each year, organizations and entities, registered to apply for Federal grants through Grants.gov must renew their registration with SAM. **Each year organizations and entities must renew their registration with SAM. Failure to renew SAM registration prior to application submission will prevent an applicant from successfully applying via Grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent CMS from issuing your agency an award under this program. Applicants should begin the SAM registration process as soon as possible after the announcement is posted to ensure that it does not impair your ability to meet required submission deadlines.** Applicants must successfully register with SAM prior to submitting an application or registering in the Federal Funding Accountability and Transparency Act Sub-award Reporting System (FSRS) as a prime award recipient user; award recipients **may make sub-awards only to entities that have DUNS numbers.**

Organizations must report executive compensation as part of the registration profile at https://www.sam.gov/portal/public/SAM/ by the end of the month following the month in which this award is made, and annually thereafter (based on the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109-282), as amended by Section 6202 of Public Law 110-252 and implemented by 2 CFR Part 170). The Grants Management Specialist assigned to monitor the sub-award and executive compensation

reporting requirements is Iris Grady, who can be reached at divisionofgrantsmanagement@cms.hhs.gov.

*Applicants were previously required to register with the Central Contractor Registration (CCR). The CCR was a government-wide registry for organizations that sought to do business with the federal government. CCR collected validated, stored, and disseminated data to support a variety of federal initiatives. This function is now fulfilled by SAM. SAM has integrated the CCR and will also incorporate seven other Federal procurement systems into a new, streamlined system. If an applicant had an active record in CCR prior to the rollout of SAM, an active record would be available in SAM. However, more than a year has passed since the rollout of SAM, so entities must ensure its registration with CCR (through SAM) is still active prior to applying under this funding opportunity. Please consult the SAM website listed above for additional information.

Continued Eligibility

Award recipients must meet reporting and certification deadlines to be eligible throughout the initial 12 month budget period and to remain eligible for a non-competing continuation award for subsequent budget periods. In addition, grantees would need to demonstrate strong performance during the previous funding cycle(s) before additional year funding is awarded. Additionally, in subsequent funding cycles, grantees could receive decreased funding or their grant could be terminated due to poor performance.

Letter of Intent to Apply [Recommended]

Applicants are highly encouraged to submit a non-binding Letter of Intent by February 8, 2016 in order to apply. Receipt of such letters enables CMS to plan for the application review process. The Letter of Intent should be submitted electronically at http://innovation.cms.gov.

Application Information

This FOA contains all the instructions to enable a potential applicant to apply. The application should be written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and cooperative agreements.

Application Materials

Application materials will be available for download at http://www.grants.gov. Please note that HHS requires that applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with http://www.grants.gov, contact support@grants.gov or 1-800-518-4726. At Grants.gov, applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

Specific instructions for applications submitted via http://www.grants.gov**:**

- You may access the electronic application for this project at http://www.grants.gov. You must search the downloadable application page by the CFDA number.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. HHS strongly recommends that you do not wait until the application due date to begin the application

process through http://www.grants.gov because of the time needed to complete the required registration steps.

- The applicant must be register in the System for Award Management (SAM) database in order to be able to submit the application. Applicants are encouraged to register early, and must have their DUNS and EIN/TIN numbers in order to do so.
- Authorized Organizational Representative (AOR): The AOR who will officially submit an application on behalf of the organization must register with grants.gov for a username and password. The AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://www.grants.gov/web/grants/applicants/organization-registration.html. The AORs must wait one business day after successful registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines.**
- When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz POC will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
- The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
- Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file formats as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. Pages cannot be reduced in size, resulting in multiple pages on a single sheet, to avoid exceeding the page limitation. All documents that do not conform to the above specifications will be excluded from the application materials during the review process.
- After you electronically submit your application, you will receive an acknowledgement from Grants.gov that contains a Grants.gov tracking number. CMS will retrieve your application package from Grants.gov. **Please note that applicants may incur a time delay before they receive acknowledgement that the application has been accepted by the Grants.gov system. Applicants should not wait until the application deadline to apply because notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline, eliminating the opportunity to correct errors and resubmit the application. Applications submitted after the deadline, as a result of errors on the part of the applicant, will not be accepted.**

- After CMS retrieves your application package from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov.

Applications cannot be accepted through any email address. Full applications can only be accepted through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service.

All grant applications must be submitted electronically and be received through http://www.grants.gov by 1:00 pm Eastern Standard Time on the applicable due date. **Applications not successfully submitted to Grants.gov by the due date and time will not be eligible for review.** All applications will receive an automatic time stamp upon submission and applicants will receive an email reply acknowledging the application's receipt.

Please be aware of the following:

- You may search for the application package in Grants.gov by entering the CFDA number. This number is shown on the cover page of this announcement.
- If you experience technical challenges while submitting your application electronically, please contact Grants.gov Support directly at: www.grants.gov/customersupport or (800) 518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week (except on Federal holidays).
- Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved.

To be considered timely, applications must be received by the published deadline date. However, a general extension of a published application deadline that affects all applicants or only those in a defined geographical area may be authorized by circumstances that affect the public at large, such as natural disasters (e.g., floods or hurricanes) or disruptions of electronic (e.g., application receipt services) or other services, such as a prolonged blackout. This statement does not apply to an individual entity having internet service problems. In order for there to be any consideration there must be an effect on the public at large.

Grants.gov complies with Section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site including forms contained with an application package, they can email the Grants.gov contact center at support@grants.gov or call 1-800-518-4726.

9.3 Appendix 3: Accessibility Provisions for All Grant Application Packages and Funding Opportunity Announcements

CMS and its grantees are responsible for complying with federal laws regarding accessibility as noted in the Award Administration Information/Administration and National Policy Requirements Section.

The grantee may receive a request from a beneficiary or member of the public for materials in accessible formats. All award recipients under this announcement must comply with the following reporting and review activities regarding accessible format requests:

Accessibility Requirements:

1. Public Notification: If you have a public facing website, you shall post a message no later than **30** business days after award that notifies your customers of their right to receive an accessible format. Sample language may be found at: http://www.medicare.gov/aboutus/nondiscrimination/nondiscrimination-notice.html. Your notice shall be crafted applicable to your program.
2. Processing Requests Made by Individuals with Disabilities:
    a. Documents:
        i. When receiving a request for information in an alternate format (e.g., Braille, Large print, etc.) from a beneficiary or member of the public, you must:
            1. Consider/evaluate the request according to civil rights laws.
            2. Acknowledge receipt of the request and explain your process within 2 business days.
            3. Establish a mechanism to provide the request.
        ii. If you are unable to fulfill an accessible format request, CMS may work with you in an effort to provide the accessible format. You shall refer the request to CMS within 3 business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
            1. The e-mail title shall read "Grantee (Organization) Alternate Format Document Request."
            2. The body of the e–mail shall include:
                a. Requester's name, phone number, e-mail, and mailing address.
                b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers, etc.
                c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
                d. The document that needs to be put into an accessible format shall be attached to the e-mail.
                e. CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services
   i. When receiving request for an accessibility service (e.g., sign language interpreter) from a beneficiary or member of the public, you must:
      1. Consider/evaluate the request according to civil rights laws.
      2. Acknowledge receipt of the request and explain your process within 2 business days.
      3. Establish a mechanism to provide the request.
   ii. If you are unable to fulfill an accessible service request, CMS may work with you in an effort to provide the accessible service. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
      1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
      2. The body of the e–mail shall include:
         a. Requester's name, phone number, e-mail, and mailing address.
         b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
         c. The date, time, address and duration of the needed service.
         d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
         e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
         f. Any applicable documents shall be attached to the e-mail.
         g. CMS will respond to the request and respond directly to the requester.
   iii. The Grantee shall maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

3. Processing Requests Made by Individuals with Limited English Proficiency (LEP):

   a. Documents:
      i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:
         1. Consider/evaluate the request according to civil rights laws.
         2. Acknowledge receipt of the request and explain your process within 2 business days.
         3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language format request, CMS may work with you in an effort to provide the alternate language format as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the request. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
    1. The e-mail title shall read "Grantee (Organization) Alternate Language Document Request."
    2. The body of the e–mail shall include:
        a. Requester's name, phone number, e-mail, and mailing address.
        b. The language requested.
        c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
        d. The document that needs to be translated shall be attached to the e-mail.
        e. CMS may respond to the request and provide the information directly to the requester.

iii. The Grantee shall maintain record of all alternate language requests received including the requestor's name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:
    1. Consider/evaluate the request according to civil rights laws.
    2. Acknowledge receipt of the request and explain your process within **2** business days.
    3. Establish a mechanism to provide the request as applicable.

ii. If you are unable to fulfill an alternate language service request, CMS may work with you in an effort to provide the alternate language service as funding and resources allow. You shall refer the request to CMS within **3** business days if unable to provide the service. You shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:
    1. The e-mail title shall read "Grantee (Organization) Accessible Service Request."
    2. The body of the e–mail shall include:
        a. Requester's name, phone number, e-mail, and mailing address.
        b. The language requested.
        c. The date, time, address and duration of the needed service.
        d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
        e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
        f. Any applicable documents shall be attached to the e-mail.

g. CMS will respond to the request and respond directly to the requester.

iii. The Grantee shall maintain record of all alternate language service requests received including the requestor's name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

Please contact the CMS Office of Equal Opportunity and Civil Rights for more information about accessibility reporting obligations at AltFormatRequest@cms.hhs.gov.

9.4 Appendix 4: Application Check-Off List Required Contents

Required Contents

A complete proposal consists of the materials organized in the sequence below. Please ensure that the project and budget narratives are page-numbered and the below forms are completed with an electronic signature and enclosed as part of the proposal. **Everything listed below must be submitted through Grants.gov, in the required formatting, or your application will not be reviewed.**

For specific requirements and instructions on application package, forms, formatting, please see:

Section 5. Application Information

Appendix 1: Sample Budget and Narrative Justifications

Appendix 2: Application and Submission Information

Forms

- ☐ SF 424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Project Abstract Summary
- ☐ Project Site Location Form

Application Kit

- ☐ Project Narrative Attachment Form
- ☐ Implementation Plan
- ☐ Contract(s), MOU(s) or MOU equivalent(s) with state Medicaid Agencies
- ☐ Contract(s), MOU(s) or MOU equivalent(s) with Clinical Delivery Sites
- ☐ Contract(s), MOU(s) or MOU equivalent(s) with Community Service Providers (Track 3)
- ☐ Budget Narrative Attachment Form

9.5 Appendix 5: Domains of Health-Related Social Needs

9.5.1 Core Health-Related Social Needs

Each bridge organization must ensure that all community-dwelling beneficiaries are offered screening at participating clinical delivery sites for the following core health-related social needs:

- Housing instability (e.g., homelessness, inability to pay mortgage/rent, housing quality);
- Utility needs (e.g., difficulty paying utility bills);
- Food insecurity;
- Interpersonal violence (e.g., intimate partner violence, elder abuse, child abuse, etc.); and
- Transportation needs (beyond medical transportation).

9.5.2 Supplemental Health-Related Social Needs

Bridge organizations may also screen for supplemental health-related social needs. Supplemental health-related social needs, if selected, must be based on a recent assessment of community needs, such as a hospital's recently conducted community health needs assessment or a local health department's community health assessment. Supplemental health-related social needs include but are not limited to the following:

- Family and social supports (e.g., prenatal support services, child care, social isolation, respite services, caregiver support);
- Education (e.g., ESL, GED, certificate programs);
- Employment and income; and
- Health behaviors (e.g., tobacco use, alcohol and substance use, physical activity).

A Technical Expert Panel (TEP) will be convened by CMS to develop a bank of questions (using validated questions wherever possible) that bridge organizations must select from when developing their screening tools.

9.6 Appendix 6: Recommended Model Participants

Recommended Model Participants

CMS will encourage bridge organizations to engage and coordinate services with model participants to address the health-related social. The following is a list of recommended model participants:

- Community Coalitions on Health
- Local or Tribal Health Departments
- No Wrong Door System organizations including Aging and Disability Resource Centers
- Area Agencies on Aging
- City Councils or County Commissioners
- Community-Based Organizations
- Medicare Advantage Plans
- Medicaid Managed Care Organizations
- Commercial Health Insurers
- Medicaid Coordinated Care Organizations
- State or Local Behavioral Health Agencies (Substance Abuse and Mental Health)
- State or Local Education Agencies (manage school districts and all charter schools)
- State or Local Rehabilitation Agencies (support court systems)
- State or Local Housing Agencies or local Continuums of Care
- State or Local Transportation Authority
- Agencies associated with the Criminal Justice System

9.7 Appendix 7: Assessment of Program Duplication

CMS will allow bridge organizations the flexibility to deliver AHC services to their community-dwelling beneficiary populations in the most appropriate manner. Nonetheless, bridge organizations must avoid providing duplicative services and target AHC services to address service gaps. The Assessment of Program Duplication must be completed for each potentially overlapping/ duplicative program and may be helpful to identify and address overlapping services. For example, the Assessment of Program Duplication may be used to identify:

- **Gaps in service provision**. An existing program may provide navigation services for a particular subset of community-dwelling beneficiaries (e.g., community-dwelling beneficiaries with a mental health or substance abuse disorder plus a chronic condition[1]), but not for others. This checklist would help identify and provide navigation services to those community-dwelling beneficiaries that do not receive navigation under existing program criteria. Furthermore, for community-dwelling beneficiaries already receiving navigation services through an existing program, the results of the systematic screening would be shared with the community-dwelling beneficiary's current case manager/care coordinator with their consent.
- **Gaps in systematic screening for health-related social needs**. An existing program may include screening for a particular health-related social need (e.g., housing quality for community-dwelling beneficiaries with asthma; food insecurity for patients with diabetes) but may not screen for all core health-related social needs (e.g., interpersonal violence and transportation). This checklist could be used to identify and resolve a screening gap.
- **Gaps in where the intervention is delivered**. An existing program may serve community-dwelling beneficiaries accessing care in a particular setting (e.g., primary care) but not in other clinical delivery sites that participate in the AHC model (e.g., behavioral health service providers and hospital EDs). Likewise, an existing program may provide screening and navigation services to all community-dwelling beneficiaries that access a particular community service (e.g., those using senior centers) and not to community-dwelling beneficiaries who do not use this service. This checklist could be used to identify what services are already offered and where they are being offered to avoid duplication.

Failure to include this assessment in the application will deem the entire application ineligible for review.

[1] Based on eligibility criteria for Missouri's Medicaid health home.

Assessment of Program Duplication Template

Program name:

Source of funding:

Period of funding:

Current participation level among AHC community-dwelling beneficiary pool:

Narrative: Provide a brief narrative summarizing the potentially duplicative service and strategies for avoiding duplication.

Required AHC program element	Y/N	Description of existing services	Gaps AHC can address	Strategy for avoiding service duplication
Passive mode of identification (eligibility assessed as part of standard clinical care; no need to recruit community-dwelling beneficiaries or for community-dwelling beneficiaries to proactively reach out to access services)				
Geographic target area for screening: community-dwelling beneficiaries, regardless of diagnosis, eligibility category, etc.				
Contents of screening: assessment of core and supplemental health-related social needs				
Screening setting: hospitals (including ED, labor & delivery, inpatient psychiatric unit), primary care settings, behavioral health provider settings				

Required AHC program element	Y/N	Description of existing services	Gaps AHC can address	Strategy for avoiding service duplication
Development of tailored community referral summary focused on resolving health-related social needs (e.g., housing, food, interpersonal violence, transportation needs)				
Development of patient-centered action plan focused on resolving health-related social needs (e.g., for housing, food, interpersonal violence, transportation needs)				
Follow-up with community-dwelling beneficiary to attempt to resolve health-related social need(s)				
Documentation of health-related social needs and result of attempt to resolve each need				

9.8 Appendix 8: Health Resource Equity Statement

The Accountable Health Communities (AHC) model will require a Health Resource Equity Statement (HRES) (also known as a Disparities Impact Statement) to be included with each application. Applicants should collaborate with their model participants to develop the HRES. The purpose of the HRES is to assist bridge organizations and their communities with: (1) identifying and targeting minority and underserved populations in model participation; (2) assessing their geographic target area in relation to these targeted subpopulations; (3) evaluating the inclusion of subpopulations in the AHC intervention; and (4) tracking progress on outcomes and engagement of these subpopulations throughout the AHC performance period. Applicants should focus their HRES on three to five subpopulations impacted by health disparities in their communities. Subpopulations of focus may be based on: race, ethnicity, gender, disability status, language, and geographic area (e.g., rural, medically underserved area, or health professional shortage area). Applicants should consider standardized and validated measures when developing the HRES and provide the appropriate citations. The initial HRES must be included with the application. Upon award, award recipients will be required to review, update, and report on their HRES every six months and submit with quarterly reports.

Health Resource Equity Statement (HRES) Template

A. **Statement of Need:** Compare your subpopulations of focus to your population of community-dwelling beneficiaries along the following demographic aspects: (1) health status; (2) access to care and health care quality; and (3) social determinants of health, including income, neighborhood, and status of core and applicable supplemental domains of health-related social needs. The applicant should compare subpopulation data to the most locally available Medicare and Medicaid (i.e., zip, city, county, state, and national) data sources, citing applicable data sources. Describe the availability, ease of use, and attractiveness of clinical and social service resources accessible to the subpopulations of focus. Specifically, address the core domains of health-related social needs and applicable supplemental domains of health-related social needs by subpopulation. Describe any gaps in community resources that impact how these social determinants are addressed locally.

B. **Action Plan:** Develop an action plan for engaging and retaining each of the subpopulations of focus throughout the five-year AHC intervention performance period. The action plan should ensure that the AHC intervention services meet the needs of the targeted subpopulations and are provided in a culturally and linguistically appropriate manner. Consider measures of success, data availability, and tracking during the development of the action plan. Propose the unduplicated number of individuals, by subpopulation, to be served (annually and over the project period) through cooperative agreement funds. Discuss the anticipated outcomes of providing the selected AHC intervention to these sub-populations. Include a diagram comparing: (1) the current state of each subpopulation and gaps in awareness, assistance, or alignment that will be addressed through the AHC intervention and (2) the expected future state of each subpopulation that will result from the AHC intervention. Detail specific strategies for inclusion of minority and underserved communities that will facilitate AHC model participation.

C. **Performance Assessment & Data:** Describe the data-driven process by which changes in the subpopulation will be tracked and assess the following areas, including (but not limited to): (1) healthcare-seeking behaviors; (2) health-related social need service availability and use; (3) other health resources use and availability; and (4) health outcomes. Describe how data will be used to manage the project and assure continuous quality improvement to support health equity for all community-dwelling beneficiaries participating in AHC. Applicants should consider standardized and validated measures when possible and provide applicable citations.

9.9 Appendix 9: Glossary of Terms

Table 25. Glossary of Terms

Term	Definition
2-1-1	2-1-1 is a national partnership between the Alliance of Information and Referral Systems (AIRS), 211US, the United Way Worldwide and the organizations and programs that manage and deliver the 2-1-1 services at the state and local levels. 2-1-1 provides a way for individuals to access comprehensive, local information and referral services.
Bridge Organization	A convening entity responsible for: developing, sustaining and nurturing relationships with model participants, state Medicaid Agencies, and local payers (e.g., MCO, MA plans, etc.); developing and implementing program infrastructure (e.g., protocols and tools for beneficiary assessment, referral, and navigation); and data reporting and QI for cooperative agreement management, evaluation, and compliance.
Care Coordination	The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.
Clinical Summary	An after-visit summary (AVS) that provides a patient with relevant and actionable information and instructions. Visit refers to the clinical care appointment.
Community-Dwelling Beneficiaries	A Medicare or Medicaid beneficiary, regardless of age, functional status, and cultural or linguistic diversity, who is not residing in a correctional facility or long-term care institution (e.g., nursing facility) when seeking care at a participating clinical delivery site and who resides in the geographic target area. This definition includes children and adults covered under Medicaid through presumptive eligibility, and all community-dwelling beneficiaries that are dually eligible.
Community Health Worker	A trained layperson that may assist individuals and communities to adopt healthy behaviors. Conducts outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening.
Community Resource Inventory	List of AHC community services and supports that address health-related social needs identified through beneficiary screening. Every identified need must include an analogous resource or service, to include contact information, address, hours of operation, and other relevant information, and which shall be updated every six months.

Term	Definition
Community Services	A range of public health and social services and supports that aim to address health-related social needs and includes many home and community-based services (HCBS). Examples include but are not limited to: a permanent supportive housing or other homeless assistance program administered by a local housing agency under a Continuum of Care; [25] a legal services program that assists low-income persons with employment, housing and financial issues; a cross-disability peer group that addresses issues that affect men and women living with disabilities; a hospital-based violence intervention program; a transportation voucher furnished by a community service provider to increase access to employment, education, or other essential resources; services to help beneficiaries apply for benefits such as energy assistance, or nutrition assistance; environmental modifications offered through local agencies and volunteer organizations; home-delivered meals offered through the Area Agency on Aging (AAA); a peer-based group to support recovery from substance use disorders; and family caregiver supports such as respite care. Many of these services are delivered by entities that are not typically considered health care organizations.
Community Service Navigation Services	Community service navigation services are performed by the AHC navigator and involve an in-depth assessment, patient-centered action planning and follow-up with the community-dwelling beneficiary until he or she has been matched with a community service provider that meets his or her needs or the need has been documented as unresolvable. Community service navigation is distinct from clinical case management, although the AHC navigator may assist high-risk community-dwelling beneficiaries with finding clinical case management services. A community-dwelling beneficiary may receive community service navigation services through this model more than once if the following conditions are met: 1 At least 12 months after the initial screen, the community-dwelling beneficiary is screened at a participating clinical delivery site and, 2. Based on the results of the screen and his or her self-reported ED usage during that period, he or she is identified as being high-risk with a health-related social need.
AHC Navigator	Assists high-risk community-dwelling beneficiaries with accessing community services to address identified health-related social needs.
Eldercare Locator	The Eldercare Locator links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caregivers.
Gap Analysis	A comparison of the actual provision of community services against potential or desired provision of such services, thus revealing areas for improvement, including barriers that are limiting referral completion rates.
Health-related Social Need	Health-related social need refers to community-dwelling beneficiary needs that potentially impact health care but may not be part of the traditional health care system.

Term	Definition
	The *core health-related social needs* in the AHC model are defined as the following five health-related social needs: housing instability and quality (e.g., homelessness, poor housing quality, inability to pay mortgage/rent); food insecurity; utility needs (e.g., difficulty paying utility bills); interpersonal violence (e.g., intimate partner violence, elder abuse, child maltreatment); and transportation needs beyond medical transportation. The *supplemental health-related social needs* in the AHC model can include but are not limited to: family and social supports (e.g., prenatal support services, child care, social isolation, respite services, caregiver support); education (e.g., English as a Second Language (ESL), General Educational Development (GED), or other education programs impacting social determinants of health); employment and income; and health behaviors (e.g., tobacco use, alcohol and substance use, or physical activity).
High-risk Community-Dwelling Beneficiary	A high-risk community-dwelling beneficiary is a community-dwelling beneficiary with a health-related social need who self-reports 2 or more ED visits in the previous 12-month period.
Low-risk Community-Dwelling Beneficiary	A low-risk community-dwelling beneficiary is a community-dwelling beneficiary with a health-related social need who self-reports 1 or zero ED visits in the previous 12-month period.
Quality Improvement Plan	A continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes which achieve equity and improve the health of the community.
Unresolved Health-related Social Need	An AHC navigator may note that a health-related social need is unresolved if: (1) the community service to address the health-related social need is unavailable (e.g., a waiting list for housing) for more than six months; or (2) the AHC navigator has attempted to address the health-related social need with the community-dwelling beneficiary on at least three separate occasions with no resolution (e.g., the community-dwelling beneficiary is not responsive).
Usual Care	The term *usual care* describes the routine clinical care received by patients for the prevention or treatment of disease or injury. *Usual care* means care that would be routinely provided to the community-dwelling beneficiary whether or not they receive an intervention under the model, and includes care that would otherwise be covered under Medicare and/or Medicaid. For purposes of this FOA, usual care includes but is not limited to federal and state reporting requirements (e.g., mandatory reporting of child abuse and neglect), recommended screenings (e.g., screening for intimate partner violence as part of the Women's Preventive Services Guidelines), and institutional and individual practice protocols (e.g., hospital guidelines and procedures).
Vulnerable Populations	Vulnerable populations, for the purposes of this FOA, include all community-dwelling beneficiaries who are: economically disadvantaged; racial and

Term	Definition
	ethnic minorities; sexual and gender minorities; homeless children and adults; individuals living with disabilities; and, medically underserved populations, including those in rural communities.

9.10 Appendix 10: Additional References

1. Hanleybrown, F., Kania, J., & Kramer, M. (2012). Channeling Change: Making Collective Impact Work. [Web log post.] *Stanford Social Innovation Review*. Retrieved from http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work.

2. Institute of Medicine. (2014). *Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2*. Washington, DC: The National Academies Press.

3. Magnan, S., Fisher, E., Kindig, D., Isham, G., Wood, D., Eustis, M., Backstrom, C., & Leitz, S. (2012). Achieving Accountability for Health and Health Care. *Minnesota Medical Association, 95(11),* 37-39.

4. McGinnis, T., Crawford, M., & Somers, S.A. (2014). *A State Policy Framework for Integrating Health and Social Services.* (Commonwealth Fund pub. 1757, Vol. 14). The Commonwealth Fund.

5. McGinnis, J.M., Williams-Russo, P., & Knickman, J.R. (2002). The Case for More Active Policy Attention to Health Promotion. *Health Affairs, 21(2),* 78–93.

6. Turner, S., Merchant, K., Kania, J., & Martin, E. (2012). Understanding the Value of Backbone Organizations in Collective Impact: Part 1. [Web log post.] *Stanford Social Innovation Review.* Retrieved from http://www.ssireview.org/blog/entry/understanding_the_value_of_backbone_organizations_in_collective_impact_1.

---

[1] Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. (2010). *County Health Rankings* http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf.

[2] Moy, E., Chang, E., & Barrett, M. (2013). Potentially Preventable Hospitalizations – United States, 2001–2009. *Morbidity and Mortality Weekly Report, 62(3),* 139-143.

[3] Herrin, J., St Andre, J., Kenward, K., Joshi, M.S., Audet, A.M., & Hines, S.C. (2014). Community Factors and Hospital Readmission Rates. *Health Services Research, 50(1),* 20-39.

[4] Eiken, S., Sredl, K., Gold, L., Burwell, B., & Saucier, B. (2013). *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FFY 2013.* (CMS Contract No. HHSM-500-2010-00026I). http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

[5] Milstein, B., Homer, J., Briss, P., Burton, D., & Pechacek, T. (2011). Why Behavioral and Environmental Interventions are Needed to Improve Health at Lower Cost. *Health Affairs, 30(5),* 823–832.

[6] Gucciardi, E., Vahabi, M., Norris, N., Del Monte, J.P., Farnum, C. (2014). The Intersection Between Food Insecurity and Diabetes: A Review. *Current Nutrition Reports, 3(4),* 324-332.

[7] Weitzman, M., Baten, A., Rosenthal, D.B., Hoshino, R., Tohn, E., & Jacobs, D.E. (2013). Housing and Child Health. *Current Problems in Pediatric and Adolescent Health Care, 43(8),* 187-224.

[8] Kyle, T. & Dunn, J.R. (2008). Effects of Housing Circumstances on Health, Quality of Life and Health Care Use for People with Severe Mental Illness: A Review. *Health & Social Care in the Community, 16(1),*1-15.

[9] Leaver, C.A., Bargh, G., Dunn, J.R., Hwang, S.W. (2007). The Effects of Housing Status on Health-Related Outcomes in People Living with HIV: A Systematic Review of the Literature. *AIDS and Behav*ior, *11(6),* 85–100.

[10] Bonomi, A.E., Anderson, M.L., Rivara, F.P., & Thompson, R.S. (2009). Health Care Utilization and Costs Associated with Physical and Nonphysical-Only Intimate Partner Violence. *Health Services Research, 44(3),* 1052-1067.

[11] Bernard, L.S., Wexler, D.J., DeWalt, D., & Berkowitz, S.A. (2015). Material Need Support Interventions for Diabetes Prevention and Control: A Systematic Review. *Current Diabetes Reports, 15(2),* 574.

[12] Kushel, M.B., Gupta, R., Gee, L., & Haas, J.S. (2006). Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans. *Journal of General Internal Medicine, 21(1),* 71-77.

[13] Cook, J.T., Frank, D.A., Levenson, S.M., Neault, N.B., Heeren, T.C., Black, M.M., . . . & Chilton, M. (2006). Child Food Insecurity Increases Risks Posed by Household Food Insecurity to Young Children's Health. *Journal of Nutrition, 136(4),* 1073–1076.

[14] Rivara, F.P., Anderson, M.L., Fishman, P., Bonomi, A.E., Reid, R.J., Carrell, D., & Thompson, R.S. (2007). Healthcare Utilization and Costs for Women with a History of Intimate Partner Violence. *American Journal of Preventive Medicine,* 32(2), 89-96.

[15] Florence, C., Brown, D.S., Fang, X., & Thompson, H.F. (2013). Health Care Costs Associated With Child Maltreatment: Impact on Medicaid. *Pediatrics, 132(2),* 312-318.

[16] For more information, see https://www.hudexchange.info/programs/coc/.

[17] This figure is meant to serve as an example and does not mean that communities that do not have all these elements are ineligible for applying or consideration of their application. Please refer to track-specific requirements found in the FOA for required participants in the model.

[18] Garg, A., Toy, S., Tripodis, Y., Silverstein, M., & Freeman, E. (2015). Addressing Social Determinants of Health at Well Child Care Visits: A Cluster RCT. *Pediatrics, 135(2),* 296-304.

[19] Gordon, J.A, Emond, J.A, & Camargo, C.A. (2005). The State Children's Health Insurance Program: A Multicenter Trial of Outreach Through the Emergency Department. *American Journal of Public Health, 95(2),* 250-253.

[20] Garg, A., Marino, M., Vikani, A.R., & Solomon B.S. (2012). Addressing Families' Unmet Social Needs within Pediatric Primary Care: The Health Leads Model. *Clinical Pediatrics, 51(12),* 1191-1193.

[21] Shumway, M., Boccellari, A., O'Brien, K., & Okin, R.L. Cost-Effectiveness of Clinical Case Management for ED Frequent Users: Results of a Randomized Trial. *The American Journal of Emergency Medicine, 26(2),* 155-164.

[22] Andrews, N.O., Erickson, D.L., Galloway, I.J., & Siedman, E.S. (2012). *Investing in What Works for America's Communities.* Federal Reserve Bank of San Francisco and the Low Income Investment Fund.

[23] Hester, J.A., & Stange, P.V. (2014). A Sustainable Financial Model for Community Health Systems. Working paper. *National Academy of Medicine Perspectives.* Retrieved from http://nam.edu/wp-content/uploads/2015/06/SustainableFinancialModel.pdf.

[24] Sandberg, S.F., Erikson, C., Owen, R., Vickery, K.D., Shimotsu, S.T., Linzer, M., . . . & DeCubellis, J. (2014). Hennepin health: A Safety-Net Accountable Care Organization for the Expanded Medicaid Population. *Health Affairs, 33(11),* 1975-84.

[25] For more information, see https://www.hudexchange.info/programs/coc/.